Transforming Clinical Services
Phase 2 Consultation
Closing Report
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1. Introduction

1.1 Background

This Closing Report is a technical document that sets out the information necessary for Hywel Dda University Health Board (Hywel Dda UHB) to reach a decision on the proposed Transforming Clinical Services (TCS) consultation. Its purpose is to enable the Board to:

- Assess whether the formal consultation has been undertaken in line with the Welsh Government Guidance on engagement and consultation *The Guidance for Engagement and Consultation on Changes to Health Services EH/ML/0161/11*;
- Understand the process followed for options development, engagement and consultation;
- Understand the process adopted to analyse the responses;
- Understand the approach to equality impact assessment;
- Consider the themes that have emerged through the TCS public consultation;
- Note the issues that have emerged that were not subject to consultation but were raised as part of the process;
- Provide assurance that the consultation process was delivered as outlined within the project plan presented to the Board in April 2018 (which can be accessed here: Project Plan and associated appendices are accessible here under Communications and Engagement); and
- Consider a series of clinical recommendations that were informed by the areas that were subject to consultation, in conjunction with other key considerations informed by the TCS programme.

This report consolidates the work undertaken to satisfy Stages 1 and 2 of the Welsh Government Guidance on engagement and consultation *The Guidance for Engagement and Consultation on Changes to Health Services EH/ML/0161/11*, which constitute the elements that relate to pre-consultation engagement with key stakeholders to develop the strategy and agree the elements for consultation, formal engagement and options development (Stage 1); and formal consultation (Stage 2), with particular focus on Stage 2.

It aims to provide assurance of compliance with the Ministerial Guidance for Health Boards, and to detail the process undertaken to give conscientious consideration to a range of factors informing future models of health and care within Hywel Dda UHB, which includes the consultation feedback received. The report outlines the recommendations resulting from this work.
The consultation process has been subject to an independent rigorous assurance process by the Consultation Institute, who have been commissioned by Hywel Dda UHB to provide independent advisory support including quality assurance of the consultation process. The Consultation Institute has developed and deployed a tried and tested method for the quality assurance of public consultations. This quality assurance process has included the testing and review of the project plan, documentation, mid-point review, closing date and final closing report. To achieve a good practice consultation the consultation must achieve several key gateways throughout the consultation process. There are six gateways, as follows:

- **Gateway 1 - Scoping** - When the basics of the consultation are agreed
- **Gateway 2 - Project Plan** - When the consultation activities are set out and organised
- **Gateway 3 - Documentation** - Ensuring that all hard copy and electronic versions are fit for purpose and that questionnaires conform to good practice
- **Gateway 4 - Mid-Point Review** - To assess whether all relevant views are being collected
- **Gateway 5 – Conscientious Consideration** – To consider all feedback received during the consultation period and to influence the outcome
- **Gateway 6 – Closing Report** - to sign the process off and confirm the Institute’s endorsement of the consultation.

It is an iterative process, some stages are signed off prior to consultation, however the latter stages will only be signed off at the point of decision making. The Consultation Institute has confirmed that Hywel Dda UHB has achieved ‘Good Practice’ for Gateways 1-5 of the Transforming Clinical Services consultation, ‘Our Big NHS Change’.

The TCS programme has been overseen by the Health Strategy Committee (HSC) and the Design Steering Group (DSG). The HSC has been established as a Committee of the Board since July 2017. Its requirement has been derived from the agreed need for a focus on strategy development and strategic objective delivery. Membership of the HSC comprises Executive Directors and representatives from our hospital clinicians, general practitioners, nurses, therapists, health scientists and trade union.

The DSG is made up of clinical representatives from Hywel Dda UHB and partner organisations and was established to clinically lead the development of the options to be formally consulted on by the public, with accountability for ensuring the TCS programme is delivered, in accordance with the timescales directed by the Board. The group has been working together over the past 15 months to consider the challenges and opportunities in meeting the health needs of the local population.
As leaders within health and care services, the group has a clear responsibility to work to the principle of co-production to drive continuous improvement in the quality of health care provision within Hywel Dda UHB.

Hywel Dda UHB wants to provide the highest quality care, with excellent outcomes that improve the health and wellbeing of its population and respond to future needs and aspirations, reflecting the ambition of the Well-being of Future Generations (Wales) Act 2015. This will be supported by the best and most sustainable health and care services that are on a par with leading practice across the UK, Europe and the rest of the world, and underpinned by a focus on helping people to maintain their own health, wellbeing and independence, recognising that good health is much more than living longer; it is living healthier lives, from before birth to older age. Our ambitions align with those in the Social Services and Well-being (Wales) Act 2014 and the recently published Welsh Government Strategy “A Healthier Wales: Our plan for Health and Social Care”.

Hywel Dda UHB’s ambition, in common with Public Service Board partners, is to build community resilience to enable people and communities to care for themselves, prevent ill health, improve well-being, promote independence and maintain a sense of purpose. Good health involves much more than access to services and treatments; it can include housing, education, and employment, as well as social connections. Collaborative cross-sector working with a range of partners, including communities themselves, is therefore essential. This “social model for health” recognises that people want more than just to live longer, they also want to live better and with a priority on staying fit, healthy and independent. This requires a need to be proactive, and provide help as soon as it is needed and not at the point of crisis.

1.2 Structure of the Closing Report

The Closing Report will:

- Summarise the process to date, including early engagement, listening to what was heard, and options development;
- Outline the formal engagement and consultation undertaken;
- Detail the findings of the consultation and how these have been conscientiously considered, including a formal response by the Community Health Council (CHC);
- Outline a series of recommendations for consideration by Hywel Dda UHB.
1.3 What is Transforming Clinical Services

‘Transforming Clinical Services’ is a clinically led programme involving doctors, nurses and other healthcare professionals working together to consider how health and care services in Hywel Dda UHB can be Safe, Sustainable, Accessible and Kind for current and future generations. These words are important as they are based on what we have been told is important to people when they receive healthcare.

These guiding principles - Safe, Sustainable, Accessible and Kind - have been used throughout Phases 1 and 2 of the programme, to ensure focus is maintained on what really matters to patients, their families, carers and staff. We will reflect on the consultation findings in the context of these four guiding principles, to ensure that decision making is aligned to what we originally set out to achieve.

The TCS programme has considered the opportunities and challenges for the modern NHS, specific to the Hywel Dda UHB area.

The difference we want to make for our population is to:

- prevent people becoming ill and help people as soon as possible when they do become ill – this is key to providing the best healthcare for the population;
- be proactive in supporting local people, particularly those living with health issues and the carers who support them;
- provide quick diagnosis so that patients can get the treatment they need, if they need it, or move on with their lives;
- be as efficient as possible so that patients and their families are not expected to travel unnecessarily or wait too long;
- look after patients in their own bed unless they need hospital care;
- provide care that is safe and of a high quality;
- be open and honest and learn from what we do well, and when things go wrong;
- make best use of resources to get the best value for money for patients;
- look after staff so that they are more able to look after patients, fully utilising their skills.

‘Transforming Clinical Services’ is the vehicle to realise this opportunity.

Clinicians have clearly articulated a strong case for change, setting out the key challenges in safety, sustainability, accessibility and kindness. The work is led with a clear focus on the latest clinical thinking and evidence, and learning from best practice sites locally, nationally and internationally to build an evidence base to support the proposed new ways of working.
The focus is on keeping people healthy and preventing ill health, and supporting individuals to remain within their communities with appropriate access to integrated out of hospital solutions, and 24/7 community and primary care services. This approach avoids the need for treatment in hospital, unless that is the most appropriate place at the time to meet an individual’s needs - the best bed for your recovery is your own bed wherever possible.

This can be supported by better understanding the needs of our population to identify those at risk of getting ill or more unwell, to support prevention and earlier intervention. It changes the focus from a health service that treats people who are sick, to one which supports people to keep healthy and well in line with the Parliamentary Review of Health and Social Care and the ambitions set out in “Our Healthier Wales”.

The ethos of continuous engagement and co-production is at the heart of the TCS programme, building on learning from previous engagement through a range of public, staff and stakeholder activities. By continuously engaging to design the future together with staff, patients, key stakeholders and partners, Hywel Dda UHB can push the thinking beyond the traditional way of arranging NHS services by being able to truly address the needs of the population, including identifying what works to step in early to prevent ill health in the first place.

Phase 1 (Discover) of this work commenced in June 2017, looking at how well current services work and how they might be reorganised and improved. This involved input from staff, patients, public and a wide range of partners and included a 12 week listening and engagement exercise, ‘The Big Conversation’, to listen to people’s views before beginning to think about any changes that may be suggested. Over 80 different meetings, events, workshops and drop-ins were held during this time, with rich and powerful feedback from a wide range of stakeholders on which the TCS design work is built. Phase 1 also involved the establishment of programme groups for Planned; Urgent and Emergency; and Community Care, to review successful systems from around the world, and present emerging models. The findings of this work are summarised in the Phase 1 Output Report (accessed via the link).

Following approval by the Board in November 2017, the second phase, Phase 2 (Design), of work commenced. This involved the development of a range of options, building on the work undertaken in Phase 1 of the programme, which centred on the following core tasks:

- undertake further research into potential models of care, building upon the findings of Phase 1;
- provide clinical and professional expertise, representative of key clinical areas;
• bring together a group of clinicians to develop options that take into account the themes identified from Phase 1 (both engagement and programme groups);
• lead and facilitate staff workshops to test and challenge the options developed;
• develop scoring criteria and score the options developed;
• review the output of staff workshops and consider refinement of the options developed into a shortlist for consideration by the DSG;
• undertake modelling and analysis of patient activity, flow, travel times, workforce and affordability;
• facilitate a number of Enabling Groups to support the development of options.

The design work of Phase 2 has continued with a strong ethos of co-production, engaging a wide range of stakeholders in challenge events to test thinking throughout the process to develop the proposals to be consulted on. These proposals were consulted on publicly, as set out in the consultation materials, between 19 April and 12 July 2018.

The consultation process is outlined in detail within this paper in the sections that follow, and aims to give assurance that the consultation process followed is inclusive and meets the guidance issued by Welsh Government in *The Guidance for Engagement and Consultation on Changes to Health Services EH/ML/0161/11*. Supporting plans and evidence where appropriate is also provided.

1.3 Health Services in Hywel Dda University Health Board

1.3.1 The Hywel Dda University Health Board landscape

Hywel Dda UHB serves a population of around 384,000 people in Carmarthenshire, Pembrokeshire and Ceredigion, covering a quarter of the total land mass of Wales,
and also provides services for parts of the population of Powys and South Gwynedd. Hywel Dda UHB plans, organises, commissions and delivers local health services for the population, managing and paying for the care and treatment local people receive in their hospitals, health centres, GPs, dentists, pharmacists, optometrists and other healthcare settings.

Although a predominantly rural area, Hywel Dda UHB has areas of urbanisation and significant deprivation spread across its geography. Compared with the rest of Wales there are fewer people aged 25-44 and more people aged 55-79, with the latter group presenting a growing challenge to already stretched health and social care services. During the next ten years there will be a 60% increase in the number of residents aged over 65 years and a doubling of those in the 75-85 years age group.

The disparity between the best and worst healthy life expectancy is 10.9 years for women and 8.3 years for men. This results in someone who lives in a deprived part of Hywel Dda being more than twice as likely to have a long-term condition as someone from an affluent area. They are also more likely to be admitted to hospital and to have a longer length of stay because of their condition which in itself is more likely to have started at an earlier age.

Once in hospital, many patients are staying longer than is necessary when they would do better at home surrounded by a network of family and friends, supported by health, social care and voluntary organisations within their communities. This has the potential to impact on optimum recovery and independence.

1.3.2 What we have at present

We have four main hospitals:
- Bronglais Hospital in Aberystwyth
- Glangwili Hospital in Carmarthen
- Prince Philip Hospital in Llanelli
- Withybush Hospital in Haverfordwest

We have seven community hospitals:
- Amman Valley and Llandovery in Carmarthenshire
- Tregaron, Aberaeron and Cardigan in Ceredigion
- Tenby and South Pembrokeshire Hospital in Pembrokeshire

We have:
- 51 General Practices (5 managed by Hywel Dda UHB)
- 46 Dental Practices (including one orthodontic)
- 99 Community Pharmacies
- 11 Health Centres
- Numerous locations providing Mental Health and Learning Disabilities Services
Health staff, such as GP’s, district nurses and therapists, pharmacists, optometrists, dentists and support staff also provide care in people’s homes within the community.

2. The need to change

2.1 Our Changing Health Needs

Health needs in the Hywel Dda UHB area are changing in a number of ways:

- **Population Growth** - the population is expected to grow from an estimated 384,000 residents in 2016 to approximately 410,000 in 2036. Carmarthenshire’s population will grow by 11%, Ceredigion by 5% and Pembrokeshire by 3%.

- **Life expectancy is increasing** - but people will experience more years of illness and disability and so will require more support to stay well and independent. Many of the people living in the Hywel Dda area have one or more long term medical conditions (or ‘co-morbidities’). The chance of having a long term condition increases with age, as does the chance of having multiple conditions, which need many different medications.

- **Lifestyle choices are expected to get worse** – therefore more people are likely to need help and support if they are overweight or obese. Unhealthy eating and drinking choices, and smoking, contribute to the main causes of premature death in the area. The effects of poor lifestyle choices, including activity levels, take time to emerge therefore increasing demands on health and care services in the future are expected.

- **There are pockets of poverty and deprivation** - which can disadvantage some of the most vulnerable people, including the younger and older people and those who have fewer money or resources. Many health outcomes are worse in areas of high deprivation and there is a 10 year difference in healthy life expectancy between the most and least well off. 75% more people attend our accident and emergency departments in the most deprived areas compared with our least deprived.
2.2 Our Key Challenges

Hywel Dda UHB has a number of challenges which provide a huge imperative to transform the way the health and well-being of our local communities is supported.

There are huge opportunities to make better use of resources, make the most of technology, and ensure services are high quality, deliver an excellent experience for patients and attract a highly motivated and skilled workforce. The challenges faced means that doing nothing is not an option.

The first phase of work, including what we heard in the ‘Big Conversation’, identified the following key challenges:

- **Ageing population**: demand on health and care services is increasing all the time and is expected to rise dramatically as more people will be living longer. Many of them will have long term conditions requiring care and treatment.
- **Geography**: providing services which people can get to and which are fair, regardless of where they live, is difficult in such a wide geographic area.
- **Rurality**: large areas are extremely rural and isolated, which means that providing services to people in their own homes can involve significant travel time.
- **Health expectations**: people want and expect to be supported to manage their health in their own homes.
- **Variation**: there are differences in the services provided and in the way in which they are managed and delivered across our three counties. We also have a 10 year gap in healthy life expectancy in our area.

Further findings from Phase 1, captured in the [Phase 1 Output Report](#) (accessed via the link).

The findings have led to a focus on four key principles that must underpin what the local future health and care services should be: Safe, Sustainable, Accessible and Kind. These guiding principles have been followed throughout the transformation programme.

**Safe services**

Transforming the way we work provides an opportunity to deliver clinical excellence, as well as the absolute priority of safe and high quality care. This will secure the best possible experiences and outcomes for patients, and address the unacceptable variation that we currently see.

The way that services are currently organised acts as a constraint and prevents the scale of improvement needed to ensure that services are working in the best way for
patients and their families, and preventing ill-health at the earliest opportunity both now and for our future population. This requires the best use of resources - whether this is staff, money, buildings and facilities, and information - concentrating on providing, high quality evidence-based healthcare, to ensure patients get the best possible support and treatment at the right time, in the right place.

Whilst it may be necessary to compromise on this journey, clinical safety will be paramount.

**Sustainable Services**

The commitment to provide sustainable services, fit for future generations, includes both sustainable workforce and financial sustainability.

Staff are at the heart of the organisation and getting the right mix of skilled staff to provide services is one of the greatest challenges currently facing Hywel Dda UHB. By addressing the existing staffing including an over-reliance on temporary staff, there is an opportunity to deliver joined up and more cost-effective and efficient care and treatment, which will also have a positive impact on safety and quality. This will also reduce the demands placed on permanent staff, who are currently working under high pressure and have to support increasingly fragile rotas, which make retention a particular issue.

Our changing health needs will require a sustainable workforce able to offer a wide range of skills and expertise, working across settings and services in a seamless system across different organisations within our communities. This will offer a range of exciting opportunities for our staff, including new, extended and expanded roles.

Critically, addressing the current staffing challenges will release the investment required in other services, activities and better technology, particularly aligned with our ambition to develop the community model.

The way current services are configured pose significant financial challenge to the organisation. As a result difficult decisions have to be taken about how funding is allocated, and particularly requires a shift towards investment in a more sustainable financial future. This involves a more community and primary care approach, with focus on preventing ill-health in the first instance, and following the principles of Value-Based Healthcare (VBHc). This will ensure that resources are used to provide the best outcomes for the least resources, whilst also releasing capacity to invest in high value evidence-based treatments. This has to mean doing things differently.
Accessible Services

By ensuring timely access to health and care services, and improving how patients flow throughout the whole health and care system, there is an opportunity to provide more accessible services. This includes access to primary and community care services, acute care, and social care.

For example, the improved provision of community services supporting timely access to a GP and other primary care services where required, should reduce the current incidence of inappropriate hospital admissions due to a lack of suitable alternatives rather than a clinical need. The development of community and primary care services, available 24/7 and supported by a range of health and social care staff, will support the ambition to allow more people to either stay in their own home, or have care provided as close to home as possible, avoiding the need for admission to hospital unless absolutely necessary. Fully developed community services will also help to resolve the current challenge of patients staying in hospital longer than they need to, by providing the support needed to return people home as quickly as possible when they are recovered.

Reducing the pressures currently placed on emergency care will also have a knock on impact on reducing delays and cancellations to planned operations and procedures, which is an upsetting and stressful experience, as well as an inefficient use of resources.

The rural and remote nature of large parts of Hywel Dda UHB impacts on the accessibility of services and often results in patients having to travel considerable distances to access care, as well as staff to provide care. However, by careful planning alongside partners, and using different and innovative solutions involving more use of technology, the impact of this can be reduced.

Kind Services

Addressing the challenges faced by Hywel Dda UHB, which often culminate in a poor experience of health and care services due to delays or cancellations and sometimes poorer quality care, provides an opportunity to deliver far kinder services. This will need to involve excellent customer services, by listening to patient experience and making improvements where needed, and delivering the most compassionate care possible.

There is a need to look after and value every contribution made by doctors, nurses, therapists, healthcare professionals and all support staff.

The way that services are currently organised, coupled with the challenges of our rural area and poor infrastructure, means that patients may have to travel for
treatments that are cancelled, or for appointments and follow-ups that don’t necessarily need to be undertaken in the hospital. Providing kinder services means making sure the amount of time patients have to travel to access health services are as short as possible, by utilising innovative and digital solutions.

Keeping people away from health services in the first place, when they don’t require them, is one of the kindest things Hywel Dda UHB can do, therefore there is a need to focus on helping the public avoid illness and anticipate when conditions are likely to deteriorate. This will also have the benefit of reducing pressure on health services, so that those who really need to access them have the best and kindest experience. This focus on population health and prevention necessitates much closer working with other organisations, such as social care and the voluntary sector, to both keep people at home and also to reduce delays in leaving hospital so that hospital beds are only used when they are needed or where people need the attention of a specialist.

Safe, Sustainable, Accessible and Kind have been used throughout Phase 2 of the programme, as guiding principles, to ensure focus is maintained on what really matters to our patients, their families, and our staff.

We will reflect on the consultation findings in the context of these four guiding principles, to ensure that decision making is aligned to our original key drivers.

2.3 The National Context


By building on the philosophy of prudent healthcare, and on close and effective partnership working in Wales, the Welsh Government aim to make a positive impact on health and wellbeing throughout life. This will be achieved through a greater emphasis on illness prevention, on supporting people to manage their own health and wellbeing. People will be enabled to live independently for as long as they can, supported by new technology and integrated health and social care services which are delivered closer to home.
The achievement of this future vision is dependent upon the development of new models of seamless local health and social care, which will scale from local to national level.

The Parliamentary Review into the Long Term Future of Health and Social Care in Wales called for four goals for the health and social care system in Wales, which it referred to as the Quadruple Aim, namely:

| 1. Improved population health and wellbeing | 2. Better quality and more accessible health and social care services |

Delivering the vision will involve:

- **Achieving longer, healthier and happier lives** through people taking more responsibility for their own health and wellbeing, and for their family and those they care for
- **A whole system approach to health and social care** which is not just about services but a ‘wellness’ system which supports and anticipates health needs to prevent illness and reduce the impact of poor health
- **An equitable system which achieves equal health outcomes for all**
- **Services which are seamless and delivered as close to home as possible**, with integration at local and regional level and multi-disciplinary services focused on prevention and early intervention within localities. This will involve other partners beyond the NHS and local authorities and combine face to face and digital delivery
- **People only going to a general hospital when it is essential**, with hospitals providing specialised services and 24/7 accident and emergency services. Hospitals will be judged on outcomes for patients and people will spend less time there following admission.
- **Using technology to support high quality, sustainable services**, including disease detection and diagnosis, assistive technology and shared information on people and their needs

There is much synergy between the ambitions of our TCS programme and the principles that underpin “A Healthier Wales” and by sharing the vision, and taking the steps needed to get there, there is an opportunity for Hywel Dda UHB to deliver the improvements needed locally, whilst also influencing and contributing to national change.
In doing so, the design principles laid out within “A Healthier Wales” will form a foundation to plan Phase 3 of the TCS Programme. These are:

<table>
<thead>
<tr>
<th><strong>Prevention and early intervention</strong></th>
<th>Acting to enable and encourage good health and wellbeing throughout life; anticipating and predicting poor health and wellbeing.</th>
</tr>
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<tbody>
<tr>
<td><strong>Safety</strong></td>
<td>Not only healthcare that does no harm, but enabling people to live safely within families and communities, safeguarding people from becoming at risk of abuse, neglect or other kinds of harm.</td>
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<tr>
<td><strong>Independence</strong></td>
<td>Supporting people to manage their own health and wellbeing, be resilient and independent for longer, in their own homes and localities, including speeding up recovery after treatment and care, and supporting self-management of conditions</td>
</tr>
<tr>
<td><strong>Voice</strong></td>
<td>Empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on ‘what matters’ to them.</td>
</tr>
<tr>
<td><strong>Personalised</strong></td>
<td>Health and care services which are tailored to individual needs and preferences including in the language of their choice; precision medicine; involving people in decisions about their care and treatment; supporting people to manage their own care and outcomes.</td>
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<tr>
<td><strong>Seamless</strong></td>
<td>Services and information which are less complex and better co-ordinated for the individual; close professional integration, joint working, and information sharing between services and providers to avoid transitions between services.</td>
</tr>
<tr>
<td><strong>Higher value</strong></td>
<td>Achieving better outcomes and a better experience for people at reduced cost; care and treatment which is designed to achieve ‘what matters’ and which is delivered by the right person at the right time; less variation and no harm.</td>
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<tr>
<td><strong>Evidence driven</strong></td>
<td>Using research, knowledge and information to understand what works; learning from and working with others; using innovation and improvement to develop and evaluate better tools and ways of working.</td>
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<tr>
<td><strong>Scalable</strong></td>
<td>Ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations.</td>
</tr>
<tr>
<td><strong>Transformative</strong></td>
<td>Ensuring that new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add an extra permanent service layer to what we do now.</td>
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</table>

The “A Healthier Wales” plan provides a framework to respond in a coherent and integrated way to the national drivers. This, together with our work to respond to the Social Services and Well-being (Wales) Act 2014 (through the West Wales Regional Partnership Board) represents the best opportunity in a generation to work across organisational boundaries to deliver health and care services that are truly seamless and benefit the patient, their families and staff. We recognise however, that our partnerships need to extend beyond health and social care. Our collaboration with Public Services Board partners, and individuals and communities, will also be fundamental to addressing the wider determinants of health and achieving the
3. Approach to Engagement

3.1 Background

The TCS programme has fully embraced co-production and continuous engagement, or involving people every step of the way, as an essential way to truly transform health and wellbeing services for the future.

This has involved engagement with a wide range of staff and stakeholders to understand people’s experience of the current services and to co-design a future, needs led service which adheres to these principles. This approach embraces the continuous engagement commitment set out within the Welsh Government Guidance on Engagement and Consultation for Changes to Health Services, as well as the Well-being of Future Generations (Wales) Act 2015. The guidance outlines a two-stage process when dealing with substantial changes to health services, a formal engagement process followed by a formal consultation process:

- Stage 1 - formal engagement, took place from 20 June to 15 September 2017 and the feedback from this was used to inform the option development and appraisal process and are included in the Phase 1 closing report.
- Stage 2 - formal consultation, took place from 19 April 2018 to 12 July 2018 and the results of this work are included within this Phase 2 closing report.

The advice provided on the consultation process by the Consultation Institute has provided stringent quality assurance, monitored through robust governance arrangements. These adhere to the principles laid out within key Welsh Government strategy guidance and wider legislation and guidance including:

- The Social Services and Wellbeing (Wales) Act 2014
- The Well-being of Future Generations Act (Wales) 2015
- The Equality Act 2010 (Statutory Duties) (Wales) Regulations
- The Mental Capacity Act 2005
- The Human Rights Act 1998
- The Welsh Language (Wales) Measure 2011
- Welsh Government Guidance for Engagement and Consultation on Changes to Health Services
- National Health Service (Wales) Act 2006
- United Nations Convention on the rights of the child (UNCRC)
The process has been awarded ‘Good Practice’ status at each gateway to date.

The Gunning Principles (1985) set out the legal expectations of what is an appropriate consultation and are applicable to all public consultations that take place in the UK. The emphasis of the Gunning Principles is on ‘fairness’. The process must be substantively fair and have the appearance of fairness. The Gunning Principles state that:

1. **Consultation must take place when proposals are still at a formative stage**

Consultation must take place when the proposal is still at a formative stage. Decision makers cannot consult on a decision that has already been made. If the outcome is pre-determined, the consultation is unfair. Public bodies need to have an open mind during a consultation and but have some ideas about the proposals.

**Sufficient reasons must be put forward for the for proposals to allow for intelligent consideration and response**

Consultees should be aware of the basis on which a proposal for consultation has been considered and will thereafter be considered. Those consulted should be aware of the criteria that will be applied when considering proposals and what factors will be considered ‘decisive’ or ‘of substantial importance’ at the end of the process.

3. **Adequate time must be given for consideration and response**

Unless statutory time requirements are prescribed, there is no necessary time frame within which the consultation must take place. Welsh Government Guidance recommends consultations should be at least 6 weeks and the length of the consultation period should be agreed with the Community Health Council.

4. **The product of consultation must be conscientiously taken into account**

If the decision maker does not properly consider the material produced by the consultation, then it can be accused of having made up its mind; or of failing to take into account a relevant consideration.

3.2 **Internal and External Assurance**

Internal assurance for the programme is provided by the Health Strategy Committee (HSC) which has been established as a Committee of the Board since July 2017. Its requirement has been derived from the agreed need for a focus on strategy development and strategic objective delivery.
The Committee:

- Provides a forum for meaningful and purposeful engagement and discussion between the Executive Team and Clinical Leaders within Hywel Dda.
- Directly influences the priorities and work programmes of the Prevention & Health Inequalities Sub-Committee and the TCS Design Steering Group.
- Brings together the Clinical Strategy and the Prevention and Health Inequalities agenda into an overarching Health Strategy with clear linkages with Hywel Dda UHB’s key stakeholders and partners programmes of work i.e. Local Authority, NHS bodies, etc.
- Ensures alignment of the underpinning enabling strategies to the wider Health Strategy including Estates, IT & Informatics, R&D, Workforce & OD, etc.
- Receives update reports from and oversee the work of the TCS Design Steering Group including an oversight of the risks involved.
- Receives update reports from and oversee the work of the Prevention and Health Inequalities Sub-Committee including an oversight of the risks involved.
- Escalates high-level issues to the Board when necessary.

Programme governance is provided by the Design Steering Group (DSG), which meets on a monthly basis and included the following responsibilities:

- To be accountable for ensuring that the TCS Programme is delivered, in accordance with the timescales as directed by the Board.
- To develop the new strategy to deliver change, stabilising primary and secondary care by shifting the focus through a population health management approach.
- To design the services to be developed (medium and long term) that will be delivered across the Hywel Dda UHB footprint as part of an integrated, enhanced primary, community and secondary care service, as will be set out in the Clinical Services Strategy.
- To ensure actions are monitored and managed through clear lines of communication and ownership.
- To be responsible for ensuring the work of all related Groups is delivered, and hold working group leads to account as per the agreed timeline.
- To agree resource re-allocation to match defined need, improve access and enhance convenience.
- To manage programme delivery and support resource requirements to deliver the work on time and in cost.
- To manage all risks and issues for the programme and associated groups.
- To escalate high-level issues when necessary based on continuous assessment of impact throughout the lifecycle of work.
- To develop and respond to emerging engagement themes and responses to
initial case for change and ideas.

- To sign off emerging solutions and new clinical models for Board approval.
- To monitor the Consultation Plan and sign off/ approve any changes
- To monitor and approve any Equality Impact Assessments (EqIA) and Integrated Impact Assessments (IIA)
- To oversee evaluation of formal consultation any preferred option
- To oversee phased implementation of new service models.
- To balance the key interfaces between Hywel Dda UHB’s strategic programme and its operational performance, delivery and business continuity to ensure that decisions to be made in relation to short term service sustainability align to the delivery of long term strategic direction and implementation.

External assurance has been provided by the Consultation Institute for the options development and consultation processes. The Consultation Institute is an independent not for profit body that was founded to promote best practice in public consultation and engagement. The Institute works with clients facing challenging exercises, providing advice and guidance through each step of the process. Hywel Dda UHB’s TCS Programme engaged the Institute at an early stage, prior to formal consultation, to build a process that was fit for purpose, and to work with the programme in its Quality Assurance (QA) role. Those who sign up to the Institutes QA process work to meet the Institute’s standards throughout and aim to achieve good or best practice recognition through six Gateways.

The Consultation Institute, through its quality assurance process, has confirmed that Hywel Dda UHB has achieved good practice status for Gateways 1-5. With a certificate to be issued following the Board’s approval of the closing report, pending the successful achievement of Gateways 5 and 6.

3.3 Formal Engagement (Stage 1)

As a Health Board, we are fully committed to openness and transparency in all that we do. This includes engaging with our public, staff and wider stakeholders to ensure we are inclusive on any decisions that are made. Throughout the TCS Programme we have striven to achieve as wide engagement and involvement as possible.

There is commitment to act within the principles of:

- openness and transparency
- honesty and integrity
- clear visibility and sense of purpose
- fairness, equality, and inclusion across all people and communities
- accurate and timely information that is accessible to all
• confidentiality and full disclosure in all our work and information held by us

A stakeholder mapping exercise was undertaken in 2017 and was updated to support the most up-to-date project plan (which can be accessed here: Project Plan and associated appendices are accessible here under Communications and Engagement). This is a ‘live’ document that is continually updated and reviewed as the different phases and stages of work move forward, and we continue to use various methods of engagement to provide the opportunity for our public, staff and wider stakeholders to allow them to fully participate in shaping the future of health and care services for Hywel Dda UHB.

This approach of ‘co-production’ means we strive to work collaboratively and collectively with as many people as possible at every step along the way. Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation. Co-production acknowledges that people with ‘lived experience’ of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives, and helps to ground discussions in reality, and to maintain a person-centred perspective. In practice, it involves people who use services being consulted, included and working together from the start to the end of any decision that affects them, and includes people who use our services, families, carers and other service providers, with the aim of working together to create a service which works for all. Co-production has been broken down into the following elements:

• co-design, including planning of services;
• co-decision making in the allocation of resources;
• co-delivery of services, including the role of volunteers in providing the service;
• co-evaluation of the service.

This can be challenging due to the number of people who can become involved and while not everyone may wish to participate, our principle is that the opportunity to do so is always there. Additionally, there may be times when we are unaware of an interested party or group and their own individual concerns, and therefore we would always look to engage and involve those people once it has been made aware to us, and endeavour to promote the various ways people can get in touch with us.

3.3.1 Engagement through Phase 1 - The Case for Change

The starting points for the TCS programme were:
• listening to the views of local people and patients who have used our healthcare services, through our engagement exercise ‘The Big Conversation’;
• examining our current services in detail with our doctors, nurses and healthcare professionals, through three distinct programme groups for Community Care; Planned Care; and Urgent and Emergency Care, to:

- understand what currently works well;
- understand the key challenges that we face;
- identify what we can learn from successful healthcare systems across the UK and internationally;
- present emerging models of care.

These two parts of Phase 1, ran concurrently, with the messages coming from ‘The Big Conversation’ being continuously considered by the groups of staff working on the programme groups to inform their thinking as the work progressed.

‘The Big Conversation’ took place from 20 June 2017 to 15 September 2017. It involved sharing information about our services and challenges widely to approximately 4,000 interested people and groups. During this time we discussed our work on the TCS programme in over 80 different meetings, drop-in sessions, workshops and other events and activities across Hywel Dda UHB. This was an exercise where broad questions were asked about what matters to people and what good healthcare and support would look like in their view.

The proposals arrived at were informed by members of the public in the following ways:

• 409 questionnaire responses (including 19 ‘easy read’ responses);
• 80+ meetings and events;
• 3 ‘Big Conversation’ engagement events in Carmarthenshire, Ceredigion and Pembrokeshire that were open to patients, the public, carers, staff, community health councils local authorities and the third sector;
• 3 drop-in events for members of the public - one in each county;
• 14 meetings and drop-in sessions for staff;
• Meetings with the Heath Board’s Stakeholder Reference Group, a group made up of organisations and interested individuals who work closely with us; Hywel Dda UHB’s senior managers; and the Community Health Council (CHC);
• Meetings with various organisations within and outside of the local NHS, including staff groups, county councils, university partners and the Community Health Council;
• A Facebook question and answer session;
• 8 community meetings organised and run by the Mid Wales Health Collaborative;
• 21 written responses.

The views of over 600 health and care staff and professionals were brought together, to consider how health and care should be changed in the Hywel Dda UHB area. Views of a wider range of organisations, groups and individuals was also sought including community health councils (CHCs), Public Services Boards (PSBs), County Councillors, the Stakeholder Reference Group (SRG), the Mid Wales Healthcare Collaborative and equality groups (People First, deaf clubs, sheltered accommodation, the veterans network, youth forums, gypsy traveller community and 50+ forums) to ensure a broad range of views were considered and informed the work.

The key things we heard during ‘The Big Conversation’:

There were a number of themes that came through clearly in the engagement responses during ‘The Big Conversation’:

Travel and access
• People told us that they were prepared to consider travelling further if it meant they would get quicker access to specialist care and their treatment quicker.
• People also supported the idea of more services being provided locally to avoid having to travel long distances, which you are sometimes required to do at the moment.
• Some people accepted that there is a need for travel given their geographical location. However, others felt travelling long distances for healthcare services was unacceptable, with concern over the inadequate public transport networks in rural areas.
• We heard that you would welcome easier access to primary care through longer GP opening hours and shorter waiting times for appointments.

Quality of care
• This covered a variety of areas, but in particular good communication and timeliness, especially when waiting for appointments or results.
• Care closer to home and having the same people support you through all of your care was important to many people.
• Fair and equal access to healthcare was also seen as an indicator of quality.
Where to receive healthcare

- We heard a lot of support for care in the community rather than in hospital at nearly every event we held, with a lot of enthusiasm for hubs in the community or ‘one stop shops’, where different health and care needs can be dealt with under one roof in the local community.

Resources

- Some people felt that money is wasted on management, paperwork and changing services. Some also felt that there are too many managers and not enough staff.
- There was a lot of support for more services in the community and having a more flexible, multi-skilled workforce working in a joined up way with other organisations like social services or voluntary services.
- There was also a willingness to be treated by nurses and non-medical staff (rather than doctors) for some conditions, although some people raised concerns about staff not being sufficiently trained.
- The people we spoke to recognise that the public would need to be educated and informed in order to understand new roles such as physician associates and advanced nurses.
- Some of the general hospital environments (Glangwili Hospital in particular) were considered not fit for purpose now, let alone for the future.
- People also highlighted that unpaid carers are a vital resource and more should be done to support them.

Joined-up services

- A large number of people felt that services would be much more joined up if there was one electronic patient record to allow different healthcare professionals to access notes quickly to understand what had happened with a patient. However, people wanted reassurance that this would be secure with a good back-up system.

The full report of the findings can be found in the Phase 1 Output Report (accessed via the link).

3.3.2 Engagement through Phase 2 - Shaping the Future of Health and Care

The Board approved all work undertaken in Phase 1 and recommended the commencement of Phase 2 on 21 November 2017. The work in Phase 2 was focussed on shaping the future of health and care for Hywel Dda UHB and on developing the future options from a long list through to a short list of proposals to directly consult on with the public, staff and wider stakeholders.

Listening to and responding to what was heard during Phase 1, the starting point for
the proposals was to focus on:

- looking at what the future holds for the local population and examining current services to understand the impact from the challenges faced;
- engaging with the public, staff and wider partners to better understand how health and care can be improved and how future services can be designed together;
- learning from the experiences of other health systems to help to develop possible models of care for the Hywel Dda UHB area.

Getting to this stage has involved continuously pursuing the commitment to co-production, though an open and transparent approach. This has shaped all of the work to date. Co-production is fundamental to ensure that services which are designed for the future will better meet people’s needs.

At the outset of this phase of work an Options Development Action Group (ODAG) was established. This group developed initial thinking around the future of health and care, building on all the feedback that was shared during Phase 1. The vision for change was developed by working closely with local health professionals and staff, and importantly, the public, patients, organisations and groups that work with Hywel Dda UHB. These stakeholders were asked to challenge the thinking and to be involved in designing the options.

The proposals that have been developed:

- focus on what more can be done to keep people well and improve the health of our population;
- make a commitment to better resource our primary and community care services, where most patient contact is made;
- make best use of all the available resources in our communities by working together across organisations and putting more healthcare in the community – from telemedicine and virtual wards to supporting voluntary sector provision;
- change or even replace some of our hospitals and their services.

4. Options Development and Proposals for Future Models of Care

4.1 Developing the Options

After listening and responding to what was understood during the listening and engagement exercise a range of options to redesign health and care services were developed. This process was led by the Options Development Advisory Group (ODAG) clinicians - doctors, nurses, therapists and other healthcare professionals,
but also included input from a wide range of local interested people and groups including local councils, the CHC, Welsh Ambulance Service NHS Trust (WAST), and the voluntary sector.

In total, 27 options were developed and considered during this process. This large number of options was tested across several workshops and group sessions in December 2017 and January 2018 with staff and partners outside of the NHS, involving over 150 people. The purpose of these sessions was to allow staff and stakeholders the opportunity to engage with the programme and provide feedback on the options developed to date. Attendees were given the opportunity to give their views on all options by looking at the strengths, weaknesses, opportunities and threats (SWOT) for each.

This feedback provided the information necessary to start ruling out many of the options and, as a result, the options were narrowed down from 27 to nine options to be discussed in greater detail with our staff and a range of groups and individuals outside of the NHS. The remaining options were then presented at a series of stakeholder challenge and testing events to consider the long list of options. This consisted of 11 staff drop-in events and 15 challenge sessions during January and February 2018. In all, more than 430 staff and other groups, organisations and individuals were reached, ranging from clinical and support staff to regional and university partners and Social Services Directors.

The purpose of these sessions was to gather views from staff and stakeholders on the options, and they were also given the opportunity to complete SWOT analyses for each remaining option. This supported attendees to test and challenge the options, and the feedback gathered was used to further refine the options. The feedback from these events was reviewed and considered at every ODAG meeting and consequently the options were modified and developed in an iterative process, with some new options emerging as a result.

The nine options were also considered at a second large workshop, held on the 11 January 2018. The workshop was very well attended, with 90 staff and stakeholders participating, including doctors, GPs, nurses, midwives, therapists, Health Board officers, and partners from WAST, and Local Authorities. The purpose of the workshop was to review the nine options through the lens of the patient.

This was the first time Teulu Jones, our Hywel Dda family, was introduced.
Teulu Jones were developed to overcome a potential over-focus on buildings and existing facilities, and to refocus on what matters to, and the experience of, our patients. We wanted the family to be broadly representative of the population in terms of health and social issues, to reflect our demographics and live in locations that would help test the emerging models. Therefore prevalence data was looked at to inform the family design and family members were located in towns and villages would best challenge access considerations.

During the workshop scenarios were created for each family member and attendees were asked to consider how the patient would experience the system now, and then to imagine how it could look in the future, according to the options presented. Focusing through the family’s lens led to a noticeable change in the energy in the room and feedback was that this approach brought the options to life because participants could connect with the family. The approach also helped to crystallise the case for change as it made the current challenges more evident.

Further SWOT analyses were undertaken at the workshop and using Teulu Jones provided very rich outputs for consideration against the remaining options.

Following the workshops and challenge sessions there was an in-depth review of feedback received. As a result, four options were eliminated due to cumulative feedback giving valid rationale for elimination. This left a remaining five options. Following the review of all feedback to date from ODAG, Options Challenge Sessions and Staff Drop-In sessions and all decision-making to date, a further option was developed, therefore increasing the shortlisted options to six.

Full details of the options development process are available here under ‘Developing our Options’.

At this point, the six shortlisted options were reviewed by the ODAG and Design Steering Group and it was agreed that these six should go forward for scoring against an agreed set of criteria. The eight criteria were developed by a group of staff and members of local groups and organisations who were completely independent of those tasked with developing and narrowing down the options. The starting point for developing the criteria was what we heard during Phase 1, and in particular findings from ‘The Big Conversation’. For example there was a lot of support for more joined up care in the community therefore it was agreed that integration, and accessibility of services, would be important criteria. Fair and equal access to health care was also seen as an important indicator of quality, therefore supporting the inclusion of quality and safety as one of the criteria.

The options scoring process took place from 7 to 14 February 2018, which involved a workshop attended by 63 multi-disciplinary staff and representatives from partner
organisations. The attendance list included doctors, nurses, midwives, therapists, and local authority social services and voluntary sector representatives.

There were several options for how participants could give their scores, namely by completing a paper score sheet at the workshop; via online tool – SurveyMonkey; via e-mail using an Excel based form; or via e-mail using a Word based form.

In addition to the workshop, an information pack, scoring instructions and link to the scoring survey was emailed to a range of Hywel Dda clinicians and staff inviting them to score the options and to share the information with their staff and colleagues. These included:

<table>
<thead>
<tr>
<th>Hospital Triumvirates</th>
<th>Medical Staffing Committees</th>
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<tr>
<td>University Partnership Board</td>
<td>Staff Partnership Forum</td>
</tr>
<tr>
<td>Health Professionals Forum</td>
<td>Senior Nursing and Midwifery Team</td>
</tr>
<tr>
<td>Primary Care Sub-Committee</td>
<td>Therapies and Health Sciences</td>
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<tr>
<td>Local Medical Council</td>
<td>ABMU Clinicians</td>
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In total, 126 valid responses were received:

- 42% from Carmarthen, 21% Pembrokeshire, 10% Ceredigion, with a further 25% identifying themselves as working Health Board wide and 2% from Abertawe Bro Morgannwg University Health Board (ABMU);
- 67% clinical, 28% non-clinical and 5% stakeholder

The total scores were calculated and the agreed weighting was applied. This allowed for the options to be ordered from highest to lowest based on the total scores given. This information was shared with the Executive Team to enable their decision making on the options which were to become the final consultation proposals. To support this decision making, an initial high level costing analysis was undertaken to test the financial viability of options. This involved modelling the impact of providing more services within our local communities on the need for patients to attend and be admitted into our hospitals and the amount of time they might spend there, and comparing the cost of this to forecast total operating costs for 2017/18.

The initial analysis provided an indication of the likely configuration of facilities required for each of the proposals considered within this consultation. The results of this demonstrates that by supporting more patients to live well at home we could reduce pressure on our hospitals, allowing us to reduce costs, for instance by reducing our reliance on temporary and agency staff and the expensive maintenance of outdated facilities. Indicative overall annual costs for each option were estimated based on the likely configuration of hospital and community facilities that emerged from our modelling exercise. The results of this suggest that for the three options...
considered in the consultation, annual total operating costs could be reduced by between £50m and £60m, before any additional investment is made in community resources or capital projects.

The scoring and financial information was used to decide which options should progress to the next stage of formal consultation.

Further information about the scoring process can be obtained here under ‘Scoring our Options’.

4.2 The proposals for future models of care

Following a comprehensive engagement and options development process, as detailed in full above, three proposals were agreed for consultation. On 19 April 2018 the proposals were presented to the Board to seek approval to proceed to formal consultation.

4.2.1 The Strategic Vision for Community Services

All proposals are underpinned by a commitment to delivering services through a predominantly community model. This is based on provision of enhanced community and primary care that is available 24/7, delivered through integrated networks of care which includes social care and third sector provision. Community staff will be working in the local community providing care as close to home as possible.

The model proposed in the consultation is supported by community hubs and hospitals across the Hywel Dda UHB area, located close to communities providing a range of health and care services, as illustrated below, providing a menu of different health and social care services (not all provided at every site) including advice and support across the range of issues that matter to patients and their families, planned
appointments and procedures, minor injuries units, step-up and step-down intermediary care beds, point of care testing and diagnostics. Whilst the community model itself was not open to influence in the consultation, views were being sought on:

- The location of community hubs;
- The types of services to be delivered at community hubs;
- The range of professionals and organisations that should be involved in providing health and care.

4.2.2 The Three Proposals

Proposal A

Two main hospitals

1. A major new urgent and planned care hospital centrally located somewhere between Narberth and St Clears, with all planned and specialist care centralised on a single site.
2. Bronglais District General Hospital would continue to provide services for mid Wales.

Three community hospitals

1. Glangwili in Carmarthen
2. Prince Philip in Llanelli
3. Withybush in Haverfordwest

**Ten community hubs** (Please note Amman Valley does not have beds in this proposal due to availability of community beds in Glangwili and Prince Philip)

**Proposal B**

**Three main hospitals**

1. A major new urgent and planned care hospital centrally located somewhere between Narberth and St Clears, with all planned and specialist care centralised on a single site.
2. Bronglais District General Hospital would continue to provide services for mid Wales.
3. A general hospital on the existing site at Prince Philip, Llanelli.

**Two community hospitals**

1. Glangwili in Carmarthen
2. Withybush in Haverfordwest

**Ten community hubs** (Please note Amman Valley does not have beds in this proposal due to availability of community beds in Glangwili)
Proposal C

Four main hospitals

1. A new urgent care hospital centrally located somewhere between Narberth and St Clears.
2. Bronglais District General Hospital would continue to provide services for mid Wales.
3. A general hospital on the existing site at Prince Philip, Llanelli.
4. A planned care hospital at the existing Glangwili Site, Carmarthen.

One community hospital

1. Withybush in Haverfordwest

Ten community hubs (Please note Amman Valley has beds in this proposal as there are no community beds in Glangwili and Prince Philip)

4.2.3 Areas Not Open to Influence

Based on what was heard during Phase 1, a number of matters were decided upon and were not open to influence in the consultation:

- The separation of planned and unplanned care within our hospital provision, which reduces the likelihood of cancelled operations and procedures;
• The delivery of urgent care at a new urgent care hospital serving the South of Hywel Dda UHB area;
• The presence of Bronglais General Hospital in all proposals

However, the consultation did seek views on how these services could be delivered.

4.2.4 Areas Open to Influence

The consultation was focused on a number of key matters, and views were gathered on whether:

• Planned care should be delivered at a new purpose built site (co-located with Urgent and Emergency Care in some proposals), or at a re-purposed Glangwili Hospital;
• Glangwili Hospital should become a planned care hospital or a Community Hospital;
• Prince Philip Hospital should be a local general hospital or a Community Hospital
• The availability of beds at Glangwili and Withybush as Community Hospitals is associated with the reduction of beds at Amman Valley and South Pembrokeshire Hospitals;

The consultation also provided an opportunity to check whether there was anything else in terms of the proposals that hadn’t been considered or whether there were any alternative options to delivering services.

5. The Consultation (Stage 2)

Hywel Dda UHB reached agreement with the Community Health Council, in accordance with the Welsh Government Guidance for Engagement and Consultation on Changes to Health Service, 2011, that the proposals for change, if supported, would constitute a substantial change to services. The Board therefore had a statutory responsibility to undertake consultation under section 183 of the National Health Services (Wales) Act 2006.

The aim of the formal consultation was to:

• inform and provide opportunities for people (staff, patients, carers, partners, stakeholders and the general public) to share their views about how the proposals have been developed;
• describe and explain the consultation proposals and what is and is not in scope;
• seek people’s views on the proposals, including the range of services as set out in the proposals;
- ensure that a diverse range of voices is heard which reflect the communities involved in the consultation;
- understand the responses made in reply to the proposals and take them into account in decision-making;
- ensure that the consultation process maximises community engagement and complies with legal requirements and duties;
- ensure that the consultation effectively captures views and feedback from our local communities, particularly individuals and groups potentially affected by changes proposed and representatives of groups with protected characteristics.

Hywel Dda UHB was advised by the Consultation Institute to ensure a good practice consultation approach was developed, in order to maximise the level of public engagement, provide reassurance for consultees, reduce the risk of legal challenge and subsequent delays, enhance stakeholder confidence and support staff.

On the 19 April 2018, the Board received, considered and approved a range of documentation, including a Consultation Plan, supporting the commencement of a formal consultation (see annex A for the updated Consultation Plan). This triggered a 12 week public consultation process, which was open from the 19 April to the 12 July 2018.

Consultation methodologies were designed to be as accessible as possible and in a range of different formats. They provided opportunities for individuals, groups and the communities we serve to share their views on the proposals.

Teulu Jones were an important feature of the consultation, in order to help make the proposals more accessible for the public, by using people and scenarios they could relate to.

Hywel Dda UHB commissioned an external organisation, Opinion Research Services (ORS), to undertake an independent analysis of the consultation feedback on its behalf. ORS has a UK-wide reputation for social research and major statutory consultations. ORS was appointed to advise on the consultation questionnaire and independently manage and report important aspects of the consultation programme. ORS managed the questionnaire process, and analysed all responses received. They also independently facilitated and reported 17 public workshops across the three counties and seven workshops with staff across the four hospital sites to encapsulate the views of a wide range of key stakeholders. This was based on a representative resident sample to balance the open questionnaire and Health Board drop-in events.
5.1 How did we engage and communicate with people during the consultation

Hywel Dda UHB undertook a stakeholder mapping and analysis exercise to identify the key stakeholders and the best methods for engaging with them. The updated detailed plan of our communication and engagement activities is available in our Consultation Plan (annex A).

The proposals for change affect all health services and as such potentially affect all members of our communities. To give people who live in the communities we serve the opportunity to get involved and share their views, it was necessary to include a diverse range of activities across the Hywel Dda UHB footprint. There were a cross section of activities to reach as many people as possible, ranging from face to face meetings and utilising existing groups, to poster campaigns and advertising/providing content for print and broadcast media and an unprecedented level of digital communication. A particular emphasis was placed on engaging with staff and seldom heard patient and population voices. A mix of existing groups and meetings were attended and also specific targeted activities were organised. There was a commitment from the DSG to meeting people where they felt most comfortable, therefore meetings and drop-ins were arranged at a variety of existing groups and sessions as well as in public venues and community centres.

Fortnightly reviews of consultation activity were undertaken by the Design Steering Group in order to ensure sufficient reach.

To support the consultation, a wide range of materials were developed for use on multiple platforms to reach as many of the population as possible. This included a suite of formal consultation materials outlining the three proposals, which were signed off by the Consultation Institute. This included the main Consultation Document and Questionnaire in Welsh and English (the latter being designed with the support of ORS). Alternative versions included Easy Read and Large Print, Braille and an audio developed in collaboration with the Wales Council for Blind. A summary version of the consultation document was made available in the form of a short animation, which was also available in alternative formats, including British Sign Language (BSL), audio and Polish. This was particularly beneficial for the large number of our online audience, but also for people with low literacy and younger people. It was available digitally from Hywel Dda UHB’s website and social media channels, but also with non-digital audiences through use at events, on digital screens in healthcare settings and in one-to-one or smaller groups.

The documents, along with a range of other resources, can still be accessed on Hywel Dda UHB’s website: TCS web resource.
Further feedback was also gathered through a series of planned meetings and public drop in events across the three counties, including an online drop-in hosted on Facebook. These meetings were planned to gather the views of as many people as possible, with particular regard to individuals from protected characteristic groups. These were arranged by Hywel Dda UHB and facilitated by our identified TCS Champions, which consisted of clinicians, staff and Executive Directors. The feedback at these sessions was captured and shared with ORS to contribute to the analysis.

A suite of Technical Documents were developed, and referred to within the main Consultation Document. The technical documents provided further information on a range of topics included within the Consultation Document, and were made available on the TCS website (via the link above), as well as being accessible at all public drop-in events for reference during discussions with the public. Throughout the consultation, the technical documents were amended in response to feedback received from the public, for example to clarify key points or to correct for accuracy. A record of any amendments was kept, via a document control table, where relevant. The Consultation Institute advised on the development of the technical documents prior to their publication and signed off the key documents (for example the Consultation Plan) as part of the quality assurance process.

Hywel Dda UHB also produced supportive materials to regularly provide information and raise awareness of the consultation to audiences as part of an external and internal staff communications campaign. This included a dedicated web resource, frequently asked questions, regular videos (including a video targeted at young people), shorter animations, radio advertising, media releases, flyers and posters by locality of theme, and frequent social media messages. Teulu Jones was used in communication materials to help people understand what the proposals could mean for them.

Through different platforms – staff forums, media and social media – Hywel Dda UHB responded to enquiries, controversy and inaccuracy by providing advice, answers and information.

During the 12 week consultation period Hywel Dda UHB engaged with people by:

- Distributing, to the public and key stakeholders:
  - 11,760 copies of the consultation document in English and Welsh
  - 16,000 copies of the questionnaire
  - 2,500 copies of the easy read documents
  - 17,357 A4 flyers
The figures above do not include documents provided at events or meetings

- Holding 147 events or meetings, directly reaching more than 4,000 people during the consultation period, including:
  - 12 staff drop-ins in all main and community hospital sites;
  - 17 public drop-ins in community locations across the three counties of Carmarthenshire, Ceredigion and Pembrokeshire. An initial seven drop-in events were planned with an additional 10 being scheduled based on feedback from the community during the consultation period;
  - Hospital walk-arounds at the four main hospitals to speak to staff on wards and in departments;
  - Four meetings with CHC representatives;
  - A range of meetings with public sector organisations and groups such as local authorities, town councils, universities and colleges, other Health Boards, emergency services including WAST, and Public Services Boards;
  - Voluntary sector organisations and their representatives;
  - 45 meetings with groups of people with protected characteristics including carers groups, groups for people with physical and learning disabilities, ethnic minorities groups including gypsy travellers and Syrian refugees, youth forums, older persons/veterans groups, breastfeeding groups, and housing groups;
  - Attendance at existing medical and clinical meetings with GP’s, consultants, nurses, therapists and other healthcare professionals;
  - Attendance at staff representative and union meetings;
  - 16 sessions or meetings with local, regional and national politicians representing all political parties;
  - A facebook online event where people could ask questions;
  - Several meetings with campaigners and campaign groups, directly invited on the basis of their campaigning;

- Distributing hard copies of the consultation document, questionnaire and events poster to:
  - Hywel Dda Community Health Council
  - GPs and Practice Managers
  - Town and Community Councils
  - Libraries
  - Dentists, Opticians and Pharmacies

- Distributing hard copies of consultation flyers and event posters to:
  - Residential Nursing Homes and Nursing Homes
  - Siarad Iechyd/Talking Health members
  - Hywel Dda Community Council
- League of Friends
- Leisure Centres
- Merched y Wawr
- Community Hospitals
- Cylch Meithrin
- Family Centres
- Nurseries
- Parent and Toddler groups

- Distributing additional hard copies of the main consultation documents/questionnaires, easy read documents and flyers to:
  - GP Practices
  - Local Authority Customer Centres
  - Libraries
  - Community Hospitals
  - Health Centres
  - Mental Health Centres
  - Leisure Centres

- Supporting 17 public and seven staff workshops hosted independently by ORS to facilitate more detailed discussions around the proposals;

- Directly emailing more than 60 stakeholders about the consultation, including almost 1500 emails about the consultation itself; more than 1500 emails about the additional public drop in events; and more than 1500 emails reminding stakeholders of the end of the consultation and signposting to additional leaflets;

- Responding to 418 responses/comments/feedback which were logged on a TCS correspondence database;

- Answering 244 media and social media enquiries;

- Publishing 50 pieces of staff communication including 42 global emails (emails to all staff with email addresses), three staff bulletins, two team briefs and one special edition of Hywel’s Voice (Hywel Dda UHB’s hard-copy staff newsletter) dedicated entirely to the TCS programme;

- Issuing 27 media releases;

- Giving 20 broadcast media interviews;
• Producing 25 videos, webcasts and animations. The Public Board meeting on 19 April 2018, which launched the consultation, was webcast and this received a total of 1,790 views (553 live views, 1,237 archived views, 62 interactions and 17 shares. There were a further 46 views with an average view duration of 12 mins six seconds from Hywel Dda UHB’s You Tube channel. A shorter clip of clinicians received 240 views and a 1 minute section on the need to change was viewed six times on You Tube but received a reach of 4.5k on Facebook and 41 retweets and 39 likes on Twitter).

• Achieving coverage through more than 195 print media articles on the consultation published in regional and local newspapers during the 12 weeks, representing significant coverage week on week and in each of the three counties.

• Managing a dedicated consultation public web resource providing background information and the need to change, access to the consultation documents and other resources, and information about the consultation events. The consultation homepages were accessed 37,045 times and the main events page was accessed 48,726 times;

• Managing a dedicated consultation internal staff intranet resource providing background information and the need to change, access to the consultation documents and other resources, and information about the consultation events. The staff intranet received 4,349 views;

• Through all Facebook and Twitter activity, issuing in excess of 74 different social media posts. This was managed on a dedicated consultation Facebook page and on the corporate Facebook page. Activity on both pages increased during the consultation period and the average daily reach on the dedicated page was 11,839 and weekly reach was 47,948. Average daily engagement was 395, and weekly 2,337. A total of 56 videos were issued on Facebook which had an average reach of 5,201 each and 1,732 unique user views. On Twitter, the #hddchange handle was created and a social media listening tool was utilised to look at how the consultation had an impact on the volume of conversation, engagement, positive and negative sentiment and emotion reaction when benchmarked against regular brand conversation. In total 1,461 posts were collected from 769 unique users, providing a potential reach of 964,637. The top engaged day was consultation launch day, with peaks following that around video content that was proactively issued throughout;

• Holding a Facebook online public drop-in event which reached 2,335 people, with 15 members of the public actively participating and 60 Health Board responses provided to questions and comments raised.
5.2. Approach to Equality Impact Assessment

Section 149 of the Equality Act 2010 requires public bodies (including NHS Health Boards) to have “due regard” to the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

c) foster good relations between persons who share a relevant protected characteristic and persons who do not share a relevant protected characteristic.

It is necessary to understand patient and public views on proposals for change to services so that decisions can be made on the best way to deliver care that is of the highest quality, with excellent outcomes for all patients. This applies to all children, young people and adults in the Hywel Dda area, regardless of gender, age, disability, ethnicity or sexuality. It also applies equally to people with mental health problems or a learning disability, as well as people with physical health problems.

Hywel Dda UHB has undertaken a comprehensive analysis of potential equality impacts (both direct and indirect). This is used to inform decisions, taking account of where actions need to be taken in order to eliminate or mitigate any identified potential negative impacts or enhance any potential positive impacts on those affected by the proposals. In this way, the new model will be influenced by those most affected and shaped to best meet the needs of patients.

Throughout the consultation process, due regard was given to the general and specific equality duties for public sector organisations in Wales and the requirement to engage with representatives of protected groups in assessing the potential impact of proposals on these groups. This was achieved by undertaking a comprehensive stakeholder mapping and analysis exercise to identify key audiences and an equality impact assessment, further details can be found in the Project Plan (which can be accessed here: Project Plan and associated appendices are accessible here under Communications and Engagement)

Account was also taken of the best practice guidance for involving patients and the public in service change.

The CHC has reported that they were largely impressed with Hywel Dda UHB’s approach to engaging with groups that are often less well heard from or more vulnerable, which included responding to specific requests and targeted engagement with a range of other groups. However, the CHC did comment on the reported disappointment from a member of the public that Hywel Dda UHB was slow to
produce a spoken-word version of the consultation document, although ultimately it was able to do so.

5.2.1 Equality Impact Assessment

An Equality Impact Assessment (EqIA) has been completed, under the Public Sector Equality Duty, to consider how the decisions might affect a range of people in different ways. Stage one of the EqIA is the screening stage that tests the relevance of proposals to meeting the duties of the Equality Act 2010 and in relation to the potential impact of proposals on individuals and communities on the basis of equality, human rights and Welsh language. Evidence gathered at this stage identifies whether there is a need to proceed to Full EqIA.

The screening of protected characteristics, summarised in appendix 1, revealed that the proposals had high relevance to equality duties, human rights and the Welsh language and have the potential to impact on people in relation to their protected characteristics. Therefore, the decision was taken to undertake a full EqIA.

A full EqIA was undertaken prior to consultation informed by background research and population data for Hywel Dda UHB, Wales and the UK. Potential impacts, both negative and positive, were identified and further evidence to inform the EqIA process was gathered during formal consultation. The full EqIA is available here (Full EqIA).

The full EqIA has identified particular impacts in terms of travel and accessibility for protected groups. For example, certain groups are less likely to have access to their own transport (e.g. older people), or be restricted in mode of transport (e.g. disabled people) or perceive barriers to their use of public transport.

Equality impacts in terms of travel and accessibility might be compounded by other characteristics that might put people with protected characteristics at further disadvantage; for example, living in a remote area will have implications in terms of availability and regularity of public transport, and living on a low income will have implications in terms of affordability of personal or public transportation.

Available data from the 2011 Census reveal that 23 per cent of households in Wales do not have a car or van. This figure rises to 34 per cent in lone parent households and 35 per cent in non-White households, demonstrating particular impact for women (who are statistically more likely to head lone parent households) and for black and minority ethnic groups in Wales. (There is a lack of data for other protected groups.)

The changes suggested in the proposals mean that travel times and routes to services will differ for many people. Some people might be required to travel further
whereas others might have less to travel, and this will depend on the service they are accessing: for example, they might have to travel less far for community or outpatient appointments, but further if they require urgent care.

Feedback from the Big Conversation (Phase 1 listening and engagement exercise - summer 2017) revealed that travel/transport and access to healthcare services might be particularly problematic for certain groups, including the elderly, disabled, pregnant women, new mothers and those living with dementia. Background research undertaken for the purposes of the full EqIA also revealed that transgender people might be particularly impacted in terms of travel, because they report facing a number of possible barriers to using public transport in particular: fears of harassment, abuse, or mis-gendering.

Accessibility could also be impacted by people’s abilities to access services independently. This might have a particular impact on people with protected characteristics, such as people with ‘hidden’ disabilities (e.g. learning disabilities, autism spectrum disorder) who might struggle to adapt to changed facilities or new and unfamiliar locations.

Identifying positive impacts is an important part of the Full EqIA. Several potential positive impacts were identified, including:

- Local ‘networks of care’ (bringing together GP practices, dental practices, pharmacies, social care, voluntary services, community halls, places of worship, etc.) will deliver care closer to home, meaning less travel for health and care support unless a stay in hospital is necessary.
- Elements of planned care (e.g. outpatient clinics and follow-ups) will be delivered from community hubs, providing more accessible planned care across the region.
- New and re-purposed builds provide opportunities to improve accessibility and patient experience via facilities that are built to be physically accessible and compliant with equality duties around the full range of protected characteristics.

The EqIA was reviewed on a regular basis during the consultation. This included scrutiny of the notes taken at public and staff meetings received to date in order to identify emerging themes around the potential impact on staff and service users. The evidence broadly supported the findings of the initial screening in relation to potential impact on protected groups. Concerns from both public and staff consultees regarding potential negative impacts were concentrated around travel, transport, the extra costs and travel time and subsequent impact on family life and care for people with no family support, particularly (but not exclusively) in relation to older people.
and disabled people. Indeed, social isolation was a key theme, particularly in relation to older people, disabled people and those who do not have family around them. Some concerns were also raised in relation to the reliance on the use of technology and the impact on people not familiar with technology, although this may be beneficial to some groups who widely use technology, for example Deaf people and people with visual impairment.

The availability of Welsh speaking staff was identified as a key consideration.

Feedback received indicated that access to services for homeless people continues to be problematic.

The needs of carers were also highlighted as a particular concern, in terms of sufficient provision of respite beds, appropriate care packages to be arranged in a timely manner prior to discharge with more streamlined activity between health and social care, and not least, looking after the health and wellbeing needs of carers themselves.

The location of Women’s and Children’s services was an issue of concern, particularly where children are hospitalised at a distance from home.

The impact assessment identified the potential positive impacts and feedback indicated that in general, the provision of as many services as close to home as possible was seen to be positive across a range of protected groups and something that should be expanded as far as possible across a wide range of services. This, in itself, would assist with reducing the incidences of people having to travel to a location further afield to access specialist and in-patient services and would facilitate the provision of a more individualised, holistic service for patients and service users across all protected groups. Furthermore, opportunities were seen and requested for the provision the following services for those in protected characteristics groups within community hubs:

- mental health services;
- gynaecology services and sexual reproductive services, early pregnancy services;
- breast feeding cafe, maternity and health visiting services;
- initiatives to mitigate against social isolation and loneliness;

Generally speaking, other than universally applicable issues around transport, access and travel there was no feedback that protected characteristic groups may be disproportionately affected by any of the three proposals. The concerns raised by protected groups appeared to relate to their current “patient experience”, rather than the proposals themselves. It was therefore not clear whether identified protected
groups would experience any disadvantage over and above those disadvantages that they may already experience when accessing services.

However, there was a clear indication that arrangements need to be put in place to eliminate barriers faced by people having to travel further to access services or to visit relatives and friends in hospital, particularly when reliant on public transport.

Continuous engagement with and involvement of those most likely to face barriers will assist in finding solutions.

5.2.2 Consultation Events and Additional Activity with Equalities Groups

A report on the engagement activity with protected groups was scrutinised at the fortnightly Design Steering Group meetings and action was agreed to address any gaps identified. Where there were potential gaps in responses from certain protected groups, extra activities were organised in order to facilitate involvement and feedback.

At a mid-point review meeting held on 22nd May 2018, ORS provided an analysis of characteristics of the respondents to the online questionnaire to that date. This analysis also informed action to address identified gaps.

Over the course of the consultation 45 public and staff consultation events were held with protected characteristics groups. This, together with additional supporting activities ensured people who may be most impacted by the changes had an opportunity to be involved in the consultation.

The events and activities covered all protected characteristics groups, and a sample is included below:

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Activity Completed</th>
</tr>
</thead>
</table>
| Age                     | - Youth Video published on TCS website and social media  
                          - Stands at colleges across Carmarthenshire, Ceredigion and Pembrokeshire and consultation videos showing on loop in the colleges  
                          - Presentation to Pembrokeshire Voices for Equality  
                          - Attendance at Royal British Legion event and resources sent for dissemination to members via email  
                          - Resources sent for dissemination by colleges, universities (including Student’s Union) and Youth Officers  
                          - Attendance at Carmarthenshire Youth Council and Pembrokeshire Youth Assembly  
                          - Attendance at Red Roses over 60’s Club |
<p>| Disability              | - Consultation Video with BSL translation |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Reassignment</td>
<td>- Full audio version of Consultation document commissioned from RNIB.</td>
</tr>
<tr>
<td></td>
<td>- Dissemination of information by Wales Council of the Blind to all Members</td>
</tr>
<tr>
<td></td>
<td>- Attendance at Learning Disability Groups and Forum</td>
</tr>
<tr>
<td></td>
<td>- Attendance at People First groups in Carmarthenshire and Pembrokeshire</td>
</tr>
<tr>
<td></td>
<td>- Attendance at Carer’s Groups and Forum</td>
</tr>
<tr>
<td></td>
<td>- Presentation and discussion with Llanelli Deaf Club using BSL interpreter and animation</td>
</tr>
<tr>
<td></td>
<td>- Presentation to Pembrokeshire Voices for Equality</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>- Resources sent for onward dissemination to Project Coordinator (Young People) Wales and West Wales LGBT Group</td>
</tr>
<tr>
<td></td>
<td>- Presentation to Pembrokeshire Voices for Equality</td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>- Resources shared with Project Coordinator (Young People) Wales</td>
</tr>
<tr>
<td></td>
<td>- Attendance at Breastfeeding Groups</td>
</tr>
<tr>
<td></td>
<td>- Presentation to Pembrokeshire Voices for Equality</td>
</tr>
<tr>
<td></td>
<td>- Executive walk around arranged for Women and Children’s Services</td>
</tr>
<tr>
<td>Race</td>
<td>- Resources sent to EYST for onwards circulation to the Swansea and West Wales BAME forum members.</td>
</tr>
<tr>
<td></td>
<td>- Polish animation published on Facebook</td>
</tr>
<tr>
<td></td>
<td>- Attendance at South West Wales BAME Regional Meeting</td>
</tr>
<tr>
<td></td>
<td>- Presentation at Pembrokeshire Voices for Equality</td>
</tr>
<tr>
<td></td>
<td>- Gypsy and Traveller sites home visits</td>
</tr>
<tr>
<td></td>
<td>- Circulation of Polish posters</td>
</tr>
<tr>
<td></td>
<td>- Syrian Refugee Families Focus Groups</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>- Presentation at Pembrokeshire Voices for Equality</td>
</tr>
<tr>
<td></td>
<td>- Syrian Refugee Families Focus Groups</td>
</tr>
<tr>
<td>Sex</td>
<td>- Attendance at Carmarthenshire People First Men’s and Women’s Groups</td>
</tr>
<tr>
<td></td>
<td>- Presentation at Pembrokeshire Voices for Equality</td>
</tr>
<tr>
<td></td>
<td>- Attendance at Royal British Legion event and Veteran’s Group</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>- Resources sent to Swansea Bay LGBT Forum</td>
</tr>
<tr>
<td>Additional Information</td>
<td>- Attendance at Carers Forum meetings in Carmarthenshire, Ceredigion and Pembrokeshire</td>
</tr>
<tr>
<td></td>
<td>- Engagement events with homeless people</td>
</tr>
</tbody>
</table>

For further details, please see our Equality Impact Assessment Review Document annex B.

In addition to engaging with groups specifically protected under the Equality Act 2010 particular arrangements were made to engage with carers, veterans, homeless people and others who are at greater risk of experiencing socio-economic deprivation.
During the consultation period ORS received the following feedback:

*In this consultation you did not even address Learning Disabled people and our organisation had to hold a meeting to invite participants from Ceredigion to take part. This did not even scratch the surface of the people who should be consulted. Once again this minority group, who probably use services more frequently, have not been consulted.*

**Mencap Ceredigion/Ceredigion Self Advocacy Group/Love Life Projects**

Whilst Mencap Ceredigion have perceived that during the twelve week consultation period people with learning disabilities were not engaged, Hywel Dda UHB did visit a number of learning disability groups across the three-counties, engaging with more than one hundred people from this client group.

**5.3 Continuous Review of Feedback**

The consultation was launched with the commitment that Hywel Dda UHB would listen and review/adapt the approach based on what was heard during consultation, therefore there were processes in place to review feedback being received and reflect on the approach being taken. This was part of Hywel Dda UHB’s commitment to continuous engagement throughout the process, to ensure that all views were heard.

The DSG met fortnightly throughout the consultation period in order to review and analyse broad themes, concerns, or questions, including directly from consultees, as they arose throughout consultation, and highlight any issues and actions to be taken. To do this, DSG received reports on communications, engagement and any political considerations. This provided an opportunity to respond flexibly and amend or expand practice where necessary (please see section below for information on what was heard and how Hywel Dda UHB responded).

In addition to this there was a comprehensive mid-point review which formed Gateway 4 of the consultation. The purpose of this Gateway is to assess whether all relevant views are being collected during the consultation.

The mid-point review usually takes place around week 6 of the formal consultation period, however it was agreed that an earlier checkpoint meeting around week 4 would be more appropriate for this consultation. Because the plan was developed and frontloaded with key activities during the first few weeks of the consultation it was important to have the review early to take on board any feedback and amend the approach in a timely manner during the consultation.
The checkpoint meeting was held on the 22 May 2018 with representatives from the Consultation Institute, ORS, the CHC and Hywel Dda UHB invited. Unfortunately the CHC were unable to attend but provided an update on the consultation from their perspective.

Hywel Dda UHB was requested to provide updates and evidence around the following elements of the consultation process to date:

A. **Progress against the Project Plan** (Actions and activities that have taken place; Exceptions to the plan; Update on the consultation responses; Residents’ Survey; Communications, social media activity and digital engagement; Specific organised consultation events; Distribution of documents; Consideration of issues and complaints)

B. **Successful engagement with identified stakeholders**

C. **Ongoing monitoring and management of the debate**

D. **Intelligence – what has been learnt or experienced**

The meeting focused on the above areas and discussions around the experiences, evidence and challenges took place. A considerable amount of evidence was provided. The Consultation Institute reviewed the information to assess and identify any key issues to be addressed throughout the remainder of the consultation process. The key issues, and how we responded, are detailed in the section below.

5.3.1 **What we heard and how we responded during consultation**

The feedback from the Consultation Institute, at the Mid-Point review, noted a number of points requiring further evidence:

1. Production of an updated EQIA and a plan for a regular and dynamic update
2. Monitoring of penetration of Polish and BSL translated material
3. The Rights of the Child (Article 25)
4. Dynamic engagement with protected characteristic groups
5. Clarification of the consultation materials in response to issues emerging from the consultation to date
6. Travel and transport implications
7. Risk of failure to provide quantitative balance to the consultation
8. Further engagement with stakeholders
9. Trailing a dialogue around the need for further consultation
10. Emerging issues following the mid-point review

The table in appendix 2, summarises the points and the action taken in response.
In addition, the regular DSG meetings highlighted a number of key actions to be taken during the consultation period. These are detailed below, along with the specific action taken:

- The webcast of the initial Board discussion was viewed in greater numbers than anticipated therefore the original copy was obtained from Pembrokeshire County Council and was embedded into Hywel Dda UHB’s website. Shorter snippets were also provided from the webcast for people who may like to view key aspects of the meeting following the day. The success of this also prompted a second live webcasting of a meeting with Pembrokeshire councillors during the consultation and has subsequently led to Hywel Dda UHB arranging more of its public meetings in facilities which offer live webcasting.

- The Question and Answer document was kept as a live document, which was continuously updated on the website based on intelligence from enquiries received through events, correspondence, media and social media. Because the document was continuously growing a ‘top questions’ section was added so that the hot topics being discussed could be easily found.

- A great deal of questions received during the first half of consultation were on transport and timely access to emergency care therefore the decision was made to commission an additional video (to those already broadcast on planned care, community care and emergency care) to concentrate on access to emergency transport and distance to definitive treatment to provide this information. The video was well received at events and received a good reach on Facebook (1,200 reach, 1,100 post clicks and 261 actions): [https://www.youtube.com/watch?v=lJKulmeWQQg](https://www.youtube.com/watch?v=lJKulmeWQQg)

- Immediate concerns were heard from staff about the safety of their jobs therefore in response a bespoke staff bulletin was released to provide the necessary reassurance. Any further myths galvanising from staff were listened to and a separate briefing was provided about the ability of staff to voice their opinions on social media. These messages were reinforced in all face-to-face staff communication and in regular staff communications (such as team briefs).

- During the first few public drop-in events a lot of people were asking about the difference between a community hub and a community hospital – the initial response was to show people a table to outline the differences, which was available in the technical documents. However, following consideration it was concluded that a lot of the general public would not access the technical documents and therefore two infographic posters were designed to highlight the differences. These were subsequently used extensively at events, posted to key stakeholders and made available on the website and as social media messages: [TCS Leaflets](#)
Analysis demonstrated that videos were performing well on social media along with feedback that clinicians in particular were well received at events, therefore additional in-house videos from clinicians to explain the rationale for change and encourage people to get involved were developed. They were posted on the social media site (and several of them were amongst the top performing messages), and were also available on the website: TCS Videos

The aim was to address all inaccuracies as they came to Hywel Dda UHB’s attention and after the mid-point of the consultation some of the most common myths circulating were addressed through the provision of information which attempted to allay concerns in a non-aggressive or derogatory way: https://www.youtube.com/watch?v=5bfZCZ7l_X8 Whilst the number of YouTube views were low, the Facebook reach was very good, at 16,000 reach, with 1,900 post clicks and 395 actions)

At the mid-way point communication was issued to recognise what was being heard during the consultation. As video posts were performing well, the communication took the form of a slideshow format: https://www.youtube.com/watch?v=yKVPSi7ohm8

At the mid-point review feedback was considered that the consultation was so broad that some people had difficulty in understanding what the proposals would mean for them as individuals accessing care. The consultation was therefore looked at through the lens of a general member of the public living in each of the counties according to where their main hospital was currently and ‘What care and from where?’ leaflets were produced. These were posted to stakeholders, used at events in the second half of consultation, and posted on the website: What care and from where leaflets

Feedback was received from the Staff Partnership Forum that the hard to reach staff were those who did not have digital access in work. Therefore the planned staff webinar was replaced with an extra staff drop in event in Withybush and walkarounds in each of the main hospital sites and the corporate centre and mental health site at Hafan Derwen to try and reach staff who otherwise may not have seen messages. Measures to replenish stock of documents at hospital sites was also stepped up, involving hand delivery of documents, refreshed on a two weekly basis, and the placement of countdown boards at the main entrances that replicated boards at pubic drop-in events to encourage staff to get involved.

A manual audit of a sample of Facebook messages was undertaken using the consultation website and Hywel Dda UHB’s corporate site, along with a search of public posts which used the hashtag #hddchange, so that a sample could be analysed to provide a benchmark of opinion provided on social media. This was shared at DSG meetings and included in the outcome report from ORS

Community Facebook groups were approached to help advertise local events and were supported by site administrators on the whole to help spread the
message about getting involved in consultation. A review of any Facebook groups that could reach our particularly heard to reach or protected characteristic groups was undertaken and they were then targeted with messages for their target audiences. 100 groups were approached in all and at least 37 of them promoted Hywel Dda UHB’s messages to their followers. This list has been kept in order to continue to engage with those groups in future.

As a result of the additional activity during the consultation, Hywel Dda UHB was recognised by the Consultation Institute as responding appropriately to the Mid-Point review and therefore Gateway 4 was successfully passed.

5.4 The Consultation Responses

All data from workshops, meetings, written submissions, social media and questionnaire responses were collated and analysed by ORS between the 15 July and the 10 August 2018 and a consultation analysis report was provided.

Responses from all sessions in addition to the feedback report itself was used to inform this final Consultation Closing Report, presented to the Board on 26 September 2018. This report includes an overview of the consultation, along with the data analysis and feedback and details how this has been used to inform the process of developing recommendations for consideration by Hywel Dda UHB as part of its decision-making process.

There was a broad range of feedback responses owing to the variety of ways in which residents and organisations were able to respond. The analysis report brings together the feedback received through each of these different elements and provides a comprehensive evidence base to help inform the decision-making process.

The response rate to the consultation, is detailed below:

- 7,251 questionnaire responses (online, postal and easy read), with 5,395 ‘valid’ responses (where more than one question was answered). This included 45 unofficial paper forms. Of the total, 478 NHS staff responses and 28 individual organisation responses;

- 275 written submissions (a table with details of all responses received is included at appendix 3);

- 261 residents attending the 17 ORS facilitated workshops, each completing a questionnaire during the session;
• 43 members of staff attending the seven ORS facilitated workshops;
• Notes taken at 18 public drop-in events with a total of 1,451 attendees;
• Notes taken at 44 staff events and meetings with a total of more than 1,120 attendees;
• Notes taken at 45 other meetings with stakeholder groups with over 1,300 attendees (exact attendee numbers were not recorded at every meeting therefore the actual figure is likely to be higher);
• Analysis of 1,461 Twitter posts and 595 Facebook comments
• Five petitions with a total of 50,884 signatures

5.5 The Consultation Analysis

The feedback detailed in the consultation analysis conducted by ORS set out the key findings which have emerged across all strands of the consultation, and these are summarised in the section below. The Executive Summary of the report can be found in annex C, and the full report can be accessed via the following link: Full ORS Report

5.5.1 The Case for Change

There was widespread support for the overall case for change across all elements of the consultation.

The workshop surveys identified that over four fifths (82%) of the representative cross-section of residents who took part agreed that Hywel Dda UHB should make changes to respond to the challenges outlined in the consultation document, with disagreement from only 11%. Three quarters (75%) of the NHS employees who responded to the open questionnaire also agreed that changes should be made in principal, while a fifth (20%) disagreed; and although many individuals who completed the open questionnaire were clearly dissatisfied about some of Hywel Dda UHB’s specific proposals, even amongst these respondents there was absolute majority (60%) agreement for the need for change with only one-in-three (33%) disagreeing.

5.5.2 Community Services

There was clear support for the shift towards a community model for providing healthcare services in future.
Two thirds (66%) of NHS employees agreed with the factors considered by Hywel Dda UHB for deciding which services should be provided at each community hub, with a quarter (25%) disagreeing; but opinion on this was more divided amongst other respondents to the open questionnaire (49% agreed, 41% disagreed).

There was a general lack of clarity and understanding about the specific proposals for community hospitals. Many questions were raised about how the proposals differed from the existing situation, in particular about the number of beds provided and the changes proposed to specific services at each location. Feedback also identified the uncertainties about the way in which patient pathways would change; though it was recognised that setting out all of the implications was inevitably complex given the range of different services provided in different places.

In terms of feedback on the specific proposals, opinion was clearly divided: 59% of NHS employees agreed with the proposed services to be provided at each community hub and 55% agreed with the proposed locations of community hubs (32% and 35% disagreed respectively). Over half (51%) of other respondents to the open questionnaire disagreed with the proposed services at community hubs and 53% disagreed with the proposed locations (34% and 37% agreed respectively). Feedback from the workshop surveys identified a relatively even balance between residents that agreed with the proposed locations of community hubs (46%) and those who disagreed (41%).

However open questionnaire responses clearly differed by area, as demonstrated below:

![Figure 1. Agreement and disagreement with proposed locations for community hubs by area base: individual respondents to the consultation questionnaire with valid postcodes (3,417)](image-url)
The majority of responses from residents living in those areas highlighted in red disagreed with the proposed locations of community hubs. It was evident that this was the case for most areas in Pembrokeshire, especially those nearer the coast in West Wales. However, there was majority agreement in many areas close to the Carmarthenshire border (including Narberth and Tenby).

The majority of responses from residents living in those areas highlighted in red disagreed with the proposed locations. It was evident that this was the case for most areas in Pembrokeshire, especially those furthest in coastal West Wales. However, there was majority agreement in many areas close to the Carmarthenshire border (including Haverfordwest, Narberth and Tenby).

There were a substantial number of detailed responses from across the various different elements of the consultation relating to the community hub proposals, with a lot of support for the proposed changes easing the pressure on hospital services.

Many responses focussed on fairness of access – in particular, the extent to which different parts of the area would be able to access services locally. Respondents recurrently suggested a number of locations which they believed that Hywel Dda UHB should consider providing additional hubs. Many of these additional locations were in Pembrokeshire, where there was greatest disagreement that Hywel Dda UHB’s proposed locations would provide fair access to all local communities. They included Milford Haven/Neyland, Fishguard/Goodwick and Crymych. In addition, many respondents suggested that additional community hubs should be considered in both Llandysul and Lampeter.

There was criticism from many about the loss of beds from community hospitals, especially in Amman Valley.

Further concerns were also raised about the realism of the proposals, the practicalities of implementation, the extent to which adequate resources would be available and the need for better integration between health and social care to ensure the success of the community model. There was also some doubt about whether or not the community model could be adequately staffed, and some proposed early pilot hubs should be quickly introduced to identify problems in practice.

5.5.3 Planned and Urgent Care

There was considerable support for the proposal to separate planned and urgent care: Over two thirds of residents (69%) at the workshops agreed with the proposal (20% disagreed). Almost two thirds of NHS employees (65%) agreed with the proposal (26% disagreed). Over half (52%) of other respondents to the open questionnaire agreed (35% disagreed).
However, many caveated their support on the basis that planned and urgent care continued to be delivered on the same site.

The consultation also identified majority support for the principle of a new hospital for urgent and emergency care in the south of the Hywel Dda UHB area. An absolute majority of residents attending the workshops (55%) and NHS employees (54%) agreed with the proposal; however, just over a third (36%) of other respondents to the open questionnaire agreed.

However, despite the support for the principle of a new hospital in the south, support for the proposed location was notably lower. Less than a quarter of individual respondents to the consultation questionnaire agreed that the new hospital should be built at a location between Narberth and St Clears (23%). Two thirds of respondents disagreed (66%); and of these two thirds, over half strongly disagreed with a new hospital in this location. Agreement was higher from NHS staff (39%) and the residents who attended the workshops (38%); but almost half (46%) disagreed. This represents the highest levels of disagreement to any of the proposals from individual respondents, workshop residents and NHS staff.

Support for the proposed location differed by area, with much higher levels of agreement in the areas between Narberth and St Clears (where it is currently proposed that the hospital would be located) and surrounding locations. Support for the proposed location was also generally higher across Pembrokeshire than it was across Carmarthenshire.

Issues about access to the proposed location were raised at drop-in sessions, meetings and workshops, as well as in written submissions from some residents.

There were specific concerns about access difficulties to new hospital for patients in the Teifi Valley (between Lampeter and Cardigan) and Powys Teaching Health Board and Powys CHC both raised concerns about the loss of A&E at Glanwgili Hospital for residents of South West Powys (Llanwrtyd Wells), and asked for clarification on patient pathways given that new hospital would be too far away.

Other specific concerns included: Carmarthenshire Consultants Committee and the Senior Paediatrics Team at Bronglais and Glangwill hospitals supported a new hospital, but proposed that it should be located in Carmarthenshire to mitigate against a possible exodus of patients to ABMU, given that they considered most of the Hywel Dda population would have difficulty accessing a hospital in West Wales. Carmarthen Town Council also said that the new hospital must be in Carmarthen; identifying that it was a vibrant location with better infrastructure and transport links, the town was equidistant from Llanelli and Haverfordwest, land was available (at the showground) and there would be educational opportunities at University of Wales
Trinity St David’s. In contrast, Withybush Medical Staff Committee (MSC), whilst it was also supportive of a new hospital for the south, it suggested that it would need to be built in Pembrokeshire given remoteness of coastal communities.

The Senior Paediatrics Team at Bronglais and Glangwili hospitals also noted that a remote location could hinder recruitment, saying that experience shows that trainees are willing to consider jobs in Carmarthen but not further West – and while a number of substantive Consultant positions have been filled in Carmarthen over the last few years, it has not been easy to do so at Withybush. Similar views on the importance of the sustainability of any chosen location were echoed by others, including Withybush MSC.

There was some doubt expressed about whether any new hospital was likely to go ahead, due to funding, and the possible timeframes that might be involved.

Reassurance was also sought that the proposed investment in the south would not have detrimental impact on Bronglais Hospital, and that services at Bronglais would be retained and continue to be supported in order to maintain services for Mid Wales.

5.5.4 Support for the Proposed Options

Support for the proposed options varied across the different elements of the consultation and is summarised as follows:

- Staff focus groups: majority support for Proposal B
- Staff drop ins: support divided between Proposals A and B
- NHS staff consultation questionnaire: small majority support for Proposal B over Proposal A
- Public workshops: slight majority said Proposal A is preferable to Proposals B and C
- Public drop ins: support divided between Proposals A and B
- Individual consultation questionnaire responses: support highest for Proposal B

Support for the proposals also varied notably by area:

- Ceredigion: support for Proposal A followed by Proposal B
- Carmarthenshire: support for Proposal B followed by Proposal C
- Pembrokeshire: support for Proposal A with substantial support for an alternative option (many focussing on retaining services at Withybush Hospital)
The distribution of opinions from the open questionnaire responses across smaller areas is shown below:

Figure 2.
Majority support for the proposed options by area base: Responses provided by individual respondents to the consultation questionnaire with valid postcodes (3,003)

There is greatest support for Proposal A in many areas near to the proposed new hospital, and also many areas around Bronglais Hospital.

Areas surrounding Llanelli support Proposal B, although this proposal also has majority support in some southern parts of Ceredigion and some central areas in the south.

Proposal C has greatest support in south east Carmarthenshire (including Cross Hands and the Amman Valley), though again there is majority support for this proposal in some southern parts of Ceredigion.

The majority of residents across many parts of West Wales support another alternative; and an alternative option has majority support in eastern Carmarthenshire. It is notable that there are very few locations without a majority preference across all respondents in the area.

5.5.5 Meeting the challenges

Respondents were asked to evaluate the extent to which each of the proposals would meet the challenges facing Hywel Dda UHB. There were very low levels of agreement that any of the three proposed options would successfully meet the challenges.
Highest levels of agreement were from NHS staff, with 44% agreeing that Proposal B would meet the challenges faced by Hywel Dda UHB, followed by Proposal A (38%) and Proposal C (36%).

Individual respondents to the open questionnaire showed similar patterns of agreement, though the extent of agreement was lower overall with 34% agreeing that Proposal B would meet the challenges, with less than a quarter agreeing that Proposal A (22%) and Proposal C (24%) would do so. There were also high levels of disagreement. Around two thirds of individual respondents disagreed that each of the three proposals would meet the challenges: Proposal A had 68% disagreement; Proposal B had 53% and Proposal C had 61%.

However, from discussions at the public workshops, it was evident that residents’ support for specific options tended to influence the extent to which they believed that they would meet the challenges. In other words, the specific proposals influenced their views on the principles as much (if not more) than the principles influencing their preferred option.

5.5.6 Proposal A

It was generally recognised that Proposal A was likely to maximise the resources available for delivering community healthcare, but there were also some concerns. These included: the failure to meet Hywel Dda UHB’s ‘equity test’ in removing facilities from the area of greatest population and social need; the ability to train the workforce needed to deliver this option; the likely impact on Morriston Hospital (and possibly Bronglais Hospital too) if residents chose to access services there instead of at the new hospital in West Wales.

However, some staff favoured Proposal A because it was the most ‘radical’ and placed greatest emphasis on the ‘community element’ of the plans: It was felt that the benefits of adopting the most cost-effective option should not be understated given the ongoing financial pressures and the aging population’s increasing needs. The Hywel Dda Local Medical Committee in particular submitted a formal written response as a group, supporting Proposal A, using this rationale. Further, views were expressed that Proposal A would maximise the resources available for investment in and the delivery of community-based services, which will be critical to the success of the overall plan. It was also seen to be the most ‘fair’ option insofar as Glanwgili Hospital, Prince Philip Hospital and Withybush Hospital would all become community hospitals; and some felt that there was little justification for Prince Philip to retain its current status given the proximity of the new hospital.

These perspectives were echoed across the different elements of the consultation.
5.5.7 Proposal B

The main advantage given in support of Proposal B was the ability to deliver services locally within the Hywel Dda UHB area for as many people as possible. Many had concerns that if Prince Philip did not remain a Local General Hospital, then large numbers of residents from the most populated areas would inevitably receive services in the neighbouring ABMU. Some also argued that services should be retained as Prince Philip currently networks well with services in ABMU and alleviates pressure from Morriston.

However, under Proposal B there were specific concerns raised about the uncertainty about community beds being provided in Llanelli; and whilst it was recognised that community beds would be provided in Carmarthen, there was also concern about there being no beds retained at Amman Valley Hospital.

5.5.8 Proposal C

In general, there was very little support for splitting planned and urgent care across two sites. It is therefore perhaps not surprising that there was only limited support for Proposal C with many consultation responses suggesting that this option would not be viable.

5.5.9 Another Alternative

More than half of all respondents who supported “another alternative” were resident in areas of West Wales. Many of these responses focussed on retaining services at Withybush Hospital and there was widespread disagreement from residents in these areas that the hospital should become a community hospital. However, there was a clear understanding from both staff and stakeholders about Hywel Dda UHB’s reasoning behind this decision, who generally supported the proposed changes for Withybush – as long as the new hospital is located closer to Narberth than Whitland or St Clears, and that Withybush would become ‘an excellent’ community hospital with a wide range of services and sufficient number of beds.

Nevertheless, it was evident that concerns about access remained and other feedback cited the prevalence of ‘high risk’ sites in the county, the poor public transport and difficult road infrastructure given Pembrokeshire’s rural nature, and long journeys along very busy A40.

5.5.10 Other Feedback

There were a range of other issues repeated in feedback across all of the options. One of the most important was the recognition that the community model needed to
be in place before any changes were introduced to acute care. Other points raised included:

- there should be no loss of services and no downgrading of services at existing hospitals unless and until the new build has been completed;
- a range of issues relating to the location of the new hospital and the associated travel and transport implications in terms of distance, the poor road infrastructure, public transport links and increased pressure on ambulance service, due to more and longer transfers;
- the realistic impacts on patient flow to ABMU (under all options to greater or lesser degree) and the need for the Health Board’s to work together to mitigate the likely impacts;
- the need to ensure that the emergency medical retrieval and transfer service (EMRTS) is available 24 hours a day; and
- whilst the services to be provided at Bronglais Hospital are the same under each of the proposals, a number of consultation responses warned against it being ‘forgotten about’.

In general, feedback from staff groups almost universally supported the need for change. The notable exception was the Senior Paediatrics Team at Glangwili Hospital, who believe that the current model (following reconfiguration) ‘makes sense’ and is working well and do not feel that the proposed changes are best for women and children.

Despite the support from NHS staff, it is clear that there are significant public concerns about the proposals. During the consultation period, five different petitions were organised which collectively received over fifty thousand signatures, further detail is contained in section 5.5.14 below.

There was also extensive debate on social media relating to the issues, which largely reflected feedback received through other elements of the consultation. It is evident that these are not constrained exclusively to the consultation proposals, but relate to the wider provision of healthcare services in the area. It is evidence that a number of commentators care very passionately about the issue.

5.5.11 The Consultation Process

The consultation process was praised by some respondents as ‘extensive’, ‘rigorous’ and ‘fair’ with a clear commitment to staff, stakeholder and public engagement.

Whilst it was suggested that there was inadequate publicity for some early events, additional meetings were arranged in certain areas. Based on the feedback
received, it is evident that staff, stakeholders and residents were able to take part in the consultation and to share their views.

Some feedback received suggested that respondents felt there was a lack of in-depth data or clearly presented evidence in the consultation document to inform their response. Others were critical on the similarities between the proposals and the uncertainties that remained, in particular about the new hospital.

There was a general lack of clarity and understanding about the proposals for community hospitals; and some felt the new hospital (and its location) had detracted from the other issues.

5.5.12 The Political View

The meetings with and submissions from politicians and political groups showed widespread agreement with the need for change and for the shift to a community model in principle. The proposed community hubs in particular were welcomed by many as the ‘best chance yet’ to deliver seamless joined-up care for residents that aims to keep people at home, living independently and promoting public health.

Some issues and concerns were raised though, particularly around: the need for community services to be properly staffed and resourced; the need for the community model to be fully functional prior to any changes to hospital services; and the importance of closer integration between health and social care in determining the success of the proposed changes.

In terms of hub locations, some were worried about the loss of beds at Amman Valley Hospital, and others suggested a need for an additional hub for the Lampeter area. Further, the idea of a ‘pilot’ community hub was suggested.

The fact that Bronglais remains relatively unaffected by the proposals was welcomed by some politicians, though groups “remain(s) concerned and watchful about the possible “invisible” downgrading of Bronglais Hospital through, for example: diminished senior doctor and consultant cover; the introduction of Physician Associates to replace doctors; and the shift of better-qualified staff to the proposed new Urgent and Planned Care Hospital in the south”.

There was support for the new hospital in principle from several politicians, being seen as a “new and attractive proposition for clinical staff”, and that “doctors, nurses and other clinical staff often prefer to work in centres of excellence which should be easier in a new, larger hospital…and a larger hospital should enable more balanced work rotas”.


Nonetheless, there were practical concerns in considering the proposed location between Narberth and St Clears, chiefly around:

- its inaccessibility both by road due to the difficult surrounding road infrastructure and by public transport;
- Possible ongoing recruitment and retention difficulties as a result of the remoteness of the location;
- The lack of guaranteed funding for the new build;
- The potential pressure on Morriston if A&E is moved further West, necessitating an agreement/protocol with ABMU to ensure “bureaucratic barriers to… accessing services in Swansea [are] fully broken down”;
- The transition period and how services will be provided in the interim.

It should also be noted that the Pembrokeshire-based politicians and groups echoed the concerns of others in relation to the loss of A&E from Withybush, particularly with respect to: travel and access issues and the need for infrastructure improvements; the number of at-risk sites in the county; the tourist increases in summer; the knock-on effects on local communities; and the effect of historical Health Board decisions on recruitment to the hospital.

5.5.13 Equalities Related Feedback

A breakdown of the profile of the individual respondents who responded ether online or by post to the open consultation questionnaire, as well as those who attended the ORS facilitated workshops, was provided by ORS.

Additionally, Equality Data Monitoring Forms were made available at each public and staff consultation event. Attendees were pro-actively encouraged to complete the form and the information gathered provides a picture of the spread of attendees across protected groups. Completion of the Equality Data Monitoring Forms was not compulsory, and it should also be noted that respondents could choose not to fill in individual sections of the Monitoring Form. As a result, a proportion of forms received indicate a “prefer not to say” in many of the categories therefore the analysis cannot give a wholly accurate demographic picture of those participating in consultation events. A total of 504 Equality Data Monitoring Forms were received from all events.

The findings of the analysis are included below:

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<tr>
<th>Age</th>
<th>ORS Respondent Profile</th>
<th>Equalities Monitoring at Events</th>
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<tbody>
<tr>
<td>Under 25</td>
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<td>0.8%</td>
</tr>
<tr>
<td>25-34</td>
<td>6%</td>
<td>2.8%</td>
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<td>35-44</td>
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<td>Age Group</td>
<td>55-64</td>
<td>65-74</td>
</tr>
<tr>
<td>-----------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Percentage</td>
<td>22%</td>
<td>30%</td>
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**Disability**

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<td>15.9%</td>
</tr>
<tr>
<td>Disabled - limited a lot</td>
<td>15%</td>
</tr>
<tr>
<td>Disabled – limited a little</td>
<td>25%</td>
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<tr>
<td>- Prefer not to say</td>
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<tr>
<td>Not disabled</td>
<td>60%</td>
</tr>
<tr>
<td>- Prefer not to say</td>
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**Gender**

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<th>Gender</th>
<th>Percentage</th>
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<tr>
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**Gender Re-assignment**

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<tr>
<td>Identify as male</td>
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</tr>
<tr>
<td>Identify as intersex</td>
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<tr>
<td>Identify as non-binary</td>
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<tr>
<td>Preferred not to say</td>
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**Race/Ethnic Group**

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<tbody>
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<td>98%</td>
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<tr>
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**Religion or belief (including none)**

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<td>Other religion</td>
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**Sexual Orientation**

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<td>Gay</td>
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</tr>
<tr>
<td>Lesbian</td>
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</tr>
<tr>
<td>Bisexual</td>
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</tr>
<tr>
<td>Other</td>
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</tr>
<tr>
<td>Preferred not to say</td>
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</tr>
</tbody>
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**Pregnancy and Maternity**

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</tr>
</thead>
<tbody>
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<td>na</td>
</tr>
<tr>
<td>Pregnant or have been pregnant in the last 12 months</td>
<td>na</td>
</tr>
<tr>
<td>Preferred not to say</td>
<td>na</td>
</tr>
<tr>
<td>Taken maternity leave within the last year</td>
<td>na</td>
</tr>
<tr>
<td>Not having taken maternity leave in the last year</td>
<td>na</td>
</tr>
<tr>
<td>Preferred not to say</td>
<td>na</td>
</tr>
</tbody>
</table>

**Marriage and Civil Partnership**

| Married or in a civil partnership | 73% | 66.1% |
| Not married or in a civil partnership | 27% | 26.5% |
| Preferred not to say | na | 7.4% |

**Carers**

| Caring responsibilities | 36% | 31.5% |
| No caring responsibilities | 64% | 60.4% |
| Preferred not to say | na | 8% |

**Welsh Language**

| English as preferred language | na | 82% |
| Welsh as preferred language | na | 17.1% |
| Other language preferred (including BSL) | na | 1.8% |

The analysis completed by ORS highlighted that the majority of issues raised in relation to equalities impacts related to travel and transport issues for specific groups, chiefly: the elderly; those with disabilities; expectant parents; families with children and children themselves. Other suggested groups on which Hywel Dda UHB’s proposals may have an adverse impact were: those in poverty or living in socially-deprived areas (particularly in relation to the cost of travelling additional distances); those without access to private transport; those from rural, farming communities and those seeking the provision of healthcare through the medium of Welsh (it was feared that this would be less likely in a centralised hospital model).

Most of the issues raised in the events specifically for protected characteristics groups were the same as those consistently seen across all other consultation elements. There was:

- Support for the case for change;
- Support for the proposed community model in principle but with concerns around its implementation (namely in terms of staffing and resourcing, integrated working between health and social care and GP shortages);
- Support for a new hospital for the south of the Hywel Dda UHB area in principle, but with significant worries about travel and access by road and public transport to the proposed location between Narberth and St Clears - as well as how the proposed new facility will be funded and staffed; and
• A great deal of concern about the repurposing of Withybush as a community hospital, although some said they felt more positive about this after hearing more detailed information about what would be available there - and, to a lesser extent, about the possible repurposing of Glangwili and Prince Philip Hospitals.

Specific suggestions around ensuring future healthcare facilities and services are fully inclusive and designed to cater for the needs of all protected characteristics were made. These included: deaf awareness training for staff; the provision of hearing loops; consideration for blind and partially sighted patients who cannot, for example, read appointment reminder letters or visual displays; translation services for those whose first language is not English or Welsh; and learning disability/autism friendly facilities such as a ‘calming room’. With respect to the latter, it was also said that the importance of familiarity for people with autism and learning disabilities must be given consideration if they are required to be treated ‘somewhere different’.

In response to the feedback received during the consultation Hywel Dda UHB recognise that should a proposal be taken forward, it would be necessary to involve protected characteristic groups and organisations in order to ensure that the new facilities meet the needs of protected characteristic groups.

Although most of the equalities issues raised were in relation to possible negative impacts on particular groups, it should also be noted that the proposed community model was considered potentially positive for older people and those with learning disabilities in providing care closer to home and minimising travel - providing it is supported by adequate transport provision for those needing acute care further afield.

The findings of the ORS analysis broadly support the outcome of the Equalities Impact Assessment.

5.5.14 Petitions

Five petitions were organised during the consultation period as follows:

• 40,045 people signed a petition against the closure of the A&E department at Withybush Hospital
• 6,583 people signed a petition to ‘Help to Save Amman Valley Hospital From Possible Closure’;
• 3,626 people signed a petition to ‘Keep A&E at Glangwili or Build New Hospital at Carmarthen’;
• 421 people signed a petition to ‘Save our Facilities at Prince Philip Hospital’; and
• 209 people signed a petition in support of retaining Bronglais as a District General Hospital and for consultation Proposal A.

The total number of signatures, across all five petitions, is 50,884.

Full details of the petitions are available in appendix 4.

Whilst not formally received as a petition, Hywel Dda UHB is aware of a further petition relating to Prince Philip. This has not been formally submitted as a response to the consultation to Hywel Dda UHB or to Welsh Government. The wording of the petition and the number of signatories is therefore unknown but the existence of the petition indicated the strength of feeling in this area, and is therefore acknowledged as a consideration.

Evidence of the considerable local campaigning about the proposed changes to services, including often highly emotive statements, as well as the petitions are important in indicating public anxiety and therefore they must be treated seriously.

Petitions have been considered as part of the available evidence during the conscientious consideration sessions.

It is notable that petition against the closure of the A&E department at Withybush Hospital alone generated 40,045 signatures and was the largest petition ever submitted to the National Assembly for Wales. The petition calls on Welsh Government and Hywel Dda UHB to reverse its decision to downgrade Withybush and to remove A&E.

The petition was considered by the Assembly’s Petitions Committee on 17 July 2018. This Committee holds Government to account and allows for petitioners to communicate directly with Assembly Members. Petitions with more than 5,000 signatures are automatically considered for a Plenary Debate and due to the large number of signatures, the Committee asked for an urgent Plenary Debate. As a result the Committee has written to the UHB for information on the process and timescale.

The Plenary Debate is likely to be held when Assembly returns from recess on 17 September 2018, therefore the outcome cannot be reported within this Closing Report.

Following Plenary Debate, the petition will be reconsidered by the Committee.
5.6 Interpreting the Consultation Analysis

Hywel Dda UHB acknowledge the range and richness of the views that were received and analysed as part of the consultation. It is recognised that there is no clear consensus, but given the consultation is only one element of what needs to be considered as part of the decision making process, Hywel Dda UHB needs to proceed with the more detailed decisions associated with the proposals. This will involve the conscientious consideration of all available evidence with its staff, clinicians and key stakeholders.

Importantly, the very different consultation methods cannot be just combined to yield a single reconfiguration outcome that reconciles everyone’s differences and is acceptable to all the Hywel Dda UHB population – for two main reasons. First, the consultation methods differ in kind: they are qualitatively different and their outcomes cannot be just aggregated into a single result. Secondly, different parts of the Hywel Dda UHB population will inevitably have different perspectives on the proposals and there is no formula in the consultation process that can reconcile everyone’s differences in a single way forward. Furthermore, the consultation was not designed to be a democratic vote and as such decisions will not be made on numbers alone as this could risk losing the richness of everything that has been heard throughout the process.

It is also important to recognise that the outcomes of the consultation process will need to be considered alongside other information available about the likely impact of each of the proposed options, including from an equalities perspective. Whilst the consultation process highlights aspects of this information that stakeholders consider to be important, Hywel Dda UHB will need to consider the appropriate emphasis to be placed on each element. In this sense there can be no single ‘right’ interpretation of all the consultation elements and other information available to the Board in their decision-making process.

Whilst the consultation findings do present a wide range of evidence for Hywel Dda UHB to consider, there is a need to consider this in detail against everything that has been heard throughout Phases 1 and 2 of the TCS programme, and in particular against the four guiding principles of safe, sustainable, accessible and kind.

In taking everything into account, Hywel Dda UHB will need to balance the opinions of staff, residents and local groups alongside the judgements of senior clinicians and professional groups.

What is clear is that where there is lack of consensus, decisions may not be made on the basis of popularity but instead on a series of trade-off’s and compromises that not only secure the best health and care services for all but that act to mitigate the impact of, for example, the location of a hospital, which may be further away for a
minority of the population. In order to do this it will be important to take account of the issues raised in the consultation when determining the final configuration of services, responding sensitively to the concerns expressed by people, alongside other information available about likely impacts.

5.7 Feedback from the Consultation Analysis

The feedback detailed in the consultation analysis conducted by ORS enabled the identification of a number of key themes by Hywel Dda’s TCS Design Team, which have emerged across all strands of the consultation, and these are summarised below:

5.7.1 Travel, transport and access

It was evident across all strands of the consultation that travel, transport and access was a key theme, and this was consistent with what was heard during the Phase 1 engagement, ‘the Big Conversation’.

This included a range of issues highlighted by respondents relating to the proposed location of the new hospital and the associated travel and transport implications in terms of distance, the poor road infrastructure, public transport links (including both rail and bus) and parking.

The impact of travel, transport and access on particular groups was a recurrent aspect of this theme, which includes older people, people who are socially disadvantaged, people with disabilities – in particular those with sensory loss, and pregnant women. Notably, the impact on farming communities emerged as a key element.

As well as patient transport and travel, there were recurring comments around staff travel.
It was therefore key that travel, transport and access was an essential area for further consideration.

5.7.2 Infrastructure

Linked very closely to the travel, transport and access theme was the emerging theme around infrastructure. This centred on concerns that the existing road and public transport infrastructure would not support the proposed future models, particularly on the basis of the poor access that some respondents reported experiencing now. There was also challenge around how a shift to more 24/7 health and care services would be enabled by public transport networks which do not
support out of hours and weekend travel, and additionally travel from very rural areas.

Another aspect of the infrastructure theme was the view expressed frequently that the wider service infrastructure is also needed to support alternative locations and models of care, for example staff may scrutinise local school standards when considering accepting a role in an area.

It will be imperative to work closely with our Local Authority partners and the Welsh Government to identify all opportunities to strengthen the local infrastructure.

5.7.3 Ambulance Capacity

As a further associated theme to travel, transport and access, respondents to the consultation regularly referred to the impact of the proposed changes on ambulance services, and the capacity to deliver changes. There was concern that the proposed location of hospital services may result in increased pressure on ambulance services due to more and longer transfers. In relation to emergency transport, this theme related to the public’s perception of the ‘Golden Hour’ and fears that further distances to travel to hospital increases risk in emergency situations.

Further clarity and confirmation of our approach and model for managing time sensitive conditions will be needed in our communication with the public.

The capacity of the Air Ambulance was raised regularly, and specifically availability on a 24/7 basis and concerns around the sustainability of the funding model.

5.7.4 Resourcing

As is clearly evident from the consultation analysis, there was a theme relating to resourcing, and more specifically a lack of clarity around how the proposed future models of care would be resourced. This included a feeling that there was insufficient information available about the cost of a new hospital, but also queries around why funding for a potential new hospital cannot be used to invest in existing facilities. This demonstrates an evident confusion around the case for change and challenges around the current hospitals model as well as a misunderstanding of the different types of funding stream that would support any proposed changes (capital/revenue).

5.7.4.1 Delivering a new hospital

A sub-theme, linked to resourcing, related to repeated concern expressed around the lack of commitment of funding for a new hospital, and hence the likelihood of this becoming a reality. Many respondents recognised that delivery of the proposals was reliant on capital funding from Welsh Government, but that there
was little confidence that this funding would be forthcoming. Consequently, respondents frequently questioned what the ‘Plan B’ was.

There is a need to clearly articulate the process for applying for funding to progress the proposals for a new hospital to serve the population.

The resourcing theme also incorporated staffing and again a lack of information around how the proposed models would be staffed. Importantly, this included not only clinical staff but a recognition of the critical role of support staff such as porters. In this regard, respondents consistently expressed concern about the availability of potential staff in a less populated area (i.e. the proposed location for a new hospital) and the ability of existing staff, on lower grades, to travel further to work. Respondents also queried how the community model and community hubs would be effectively staffed.

A consistent element of this theme was a lack of certainty around whether the proposed models of care would in fact improve recruitment, and both the need for enhanced packages to attract staff (linked to the Infrastructure theme above i.e. schools and local services) and questions around why Hywel Dda UHB hadn’t already been doing this to address current recruitment challenges.

Finally, there was a consistent recognition that resourcing is wider than Hywel Dda UHB and that social care and third sector capacity has a significant impact on the delivery of health and care services.

As the programme moves forward into the next phase of work, the initial workforce considerations will need to be further developed into detailed workforce plans that consider all impacts and opportunities.

5.7.5 Location of the new hospital

As has been seen throughout the ORS analysis, despite there being support overall for the principle of a new hospital in the south, the reasons behind disagreement with the proposed location were relatively consistent therefore this is presented here as a theme.

This again links closely to other themes identified, predominantly Transport, travel and access – and the increased travel times to the proposed location; and Infrastructure – particularly the existing road network and availability of public transport.

A view was expressed in the feedback, particularly from the Pembrokeshire area, that the proposed location fails to take account of the increase in population caused by tourism and the distance from an urgent and emergency care hospital in the event
of an incident occurring at one of the heavy industrial sites along the Haven Waterway. There was a need to reassure respondents throughout the consultation that people with major injuries or burns from an industrial accident would be transported to University Hospital Wales in Cardiff or Morriston Hospital as they are now.

Further analysis of the alternative sites suggested during the consultation has been undertaken to inform further consideration of the findings by staff and stakeholders.

5.7.6 Community Hubs and Beds

Again, whilst the analysis demonstrated overall support for the shift towards a community model in principle, the specific criticisms of the specific proposals presented as a consistent theme. Namely, there was disagreement with the proposed locations for the community hubs, though this was less related to the 10 sites identified and more related to the gaps where hubs should be. Many respondents suggested that Hywel Dda UHB should reconsider the proposals by including additional hubs in Milford Haven/Neyland, Fishguard/Goodwick, Crymych, Llandysul and Lampeter.

The concept of hubs within a network of community care and support is a key area for further consideration.

Most of the issues raised about the location of hubs related to access, recruitment, and again surrounding infrastructure was an associated theme.

In addition to the need for more balance around the coverage of community hubs, a commonly expressed feeling related to the need for further information about what a community hub was, the services that could be delivered from them, and so on.

5.7.7 Lack of Detail

Indeed, a key theme emerging from the analysis relates to the feeling that there was a general lack of detail in the proposals, namely around what services will be located where, the number of community and hospital beds in the proposals, or as previously stated, insufficient information about the cost of a new hospital. As a result, some respondents felt it would be difficult to provide a viewpoint or make a decision on which proposal they preferred.

The communication strategy going forward will need to address the feedback received on the information provided in the consultation.

5.7.8 Transition Plan
A commonly recurring question was how long it would take to deliver the proposed changes, and an associated concern around what would happen in the meantime. This was particularly the case with regard to services that are currently under pressure and potentially fragile, such as Accident and Emergency Departments. Respondents expressed fears that services would be closed or moved before a suitable alternative was provided. Therefore, a need was seen for a clear Transition Plan, which would detail what would happen if services did become unsustainable during the transition to the new model of care. It was felt that this would allay some of the fears held by the public.

We recognise the need to reiterate that any service change will need to be as part of a phased implementation plan, linked to the impact of the introduction of an enhanced community model and the provision of urgent and emergency services in a new hospital in the south of the Hywel Dda UHB area.

5.7.9 Another alternative for Pembrokeshire

An important theme expressed by many respondents from Pembrokeshire relates to the feeling that there was a lack of choice within the proposals and that a decision had already been made because Withybush becomes a Community Hospital in all three proposals.

Consequently, there was very strong public support for another alternative across many parts of Pembrokeshire, with proposals typically involving the retention of existing services and/or enhancing the services provided at Withybush Hospital.

All alternative proposals and suggestions have been rigorously tested as part of the consideration of the findings (see in particular section 5.8.3).

5.7.10 Regional considerations

The impact of the proposals on neighbouring Health Boards was frequently acknowledged by respondents, in particular a recognition of the consequences of the location of services on patient flow from the South East to ABMU, and the strategic importance of Bronglais Hospital for health services in North Ceredigion, South Gwynedd and Powys.

As well as a potential negative impact, there was also an understanding of the possible opportunities offered by working in a more regional way.

The existing Regional Boards and Committees provide the vehicle to consider the impacts and opportunities as we move into the next phase of work.
5.7.11 Alignment with Mental Health

Repeated queries around how mental health and learning disabilities services fit with the proposals for change, particularly around how services are integrated and where they are located, highlighted the need for further clarity regarding the alignment of this programme with existing programmes linked to transforming mental health services.

There are significant opportunities to align the TCS and Transforming Mental Health (TMH) programmes further to maximise all opportunities to join up physical and mental health care and support.

5.7.12 Integration across health, social care and third sectors

Integration of health, social care and the third sector was a general theme throughout the consultation. Respondents consistently acknowledged that the proposed models are reliant on the seamless delivery of services across health, social care and the voluntary sector, both within the community, as people need to enter hospital and to support people out of hospital. However, there was concern around how this could be delivered, again in the context of Resourcing (as per the theme above) and some lack of confidence in the ability to deliver this kind of change.

There was a wide acknowledgement that community services need to be designed collaboratively with key partners such as local authorities and the third sector. The Regional Partnership Board provides us with the formal mechanism to progress the integration agenda.

5.7.13 Prevention

A common theme emerging across the consultation was a recognition of the importance of prevention, especially in the context of the acceptance of the case for change. There was public acknowledgement of the changing health needs of the population, and the responsibility of individuals and communities for better public health, and the avoidance of the need for hospital care unless it was absolutely necessary. Generally, respondents saw the role that the community model had to play in the prevention agenda, and therefore this strengthens our consideration of the approach to community care, support and treatment.

5.7.14 Primary Care
Whilst not within the scope of the consultation, a popular theme that emerged was linked to current experience of primary care, and especially current levels of access to GP’s. This again links back to the resourcing theme, and current and projected capacity concerns. As a result, the proposals for GP led services were called into question in terms of the perception of how deliverable this would be, particularly around the proposed model for GP-led Minor Injuries Units.

Primary care will need to be a key consideration in our workforce planning, particularly in relation to the enhanced community model.

5.7.15 Technology Enabled Care

Whilst increased use of technology was generally accepted within the consultation responses, such as more use of telemedicine to deliver additional services within the community, there was again some lack of confidence in Hywel Dda UHB’s ability to deliver such changes, for two main reasons. Firstly, there was an argument that technology is advancing all of the time, therefore Hywel Dda UHB should already be maximising on these opportunities; and secondly, aligned with the theme of Infrastructure, was the recognition that challenges around broadband availability for many communities would impact on the ability to deliver some of these changes.

Feasibility studies of all potential digital solutions will need to be undertaken to consider deliverability across our population.

Please see section 5.8.1 below on how these themes have been conscientiously considered, and subsequently section 7 for how they have informed the clinical recommendations.

5.8 Considering the Consultation Analysis Feedback

In order to provide assurance that the findings of the consultation have been fully and conscientiously taken into account, a period of conscientious consideration of all feedback received during the consultation period was carried out.

Assurance is provided when it can be evidenced that Hywel Dda UHB has:

- Produced a 'Fair Interpretation' of the consultation response
- Demonstrated how that has helped to learn or understand the impact of the proposals
- Demonstrated how the responses informed any recommendations.

5.8.1 The Plan for Conscientious Consideration
The Gunning Principles state that ‘the product of consultation must be conscientiously taken into account’: If the decision maker does not properly consider the material produced by the consultation then it can be accused of having made up its mind or failing to take into account a relevant consideration.

In order to ensure that the findings of the consultation were conscientiously considered, a plan was developed to undertake a series of sessions between 13 August and 17 September 2018. The sessions involved clinicians and wider staff and stakeholders, and the outcomes of these sessions have been used to determine the final clinical recommendations.

The sessions were as follows:

<table>
<thead>
<tr>
<th>Session</th>
<th>Audience</th>
<th>Date</th>
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<tbody>
<tr>
<td>Design Team Conscientious Consideration Session</td>
<td>Programme Management Office</td>
<td>13 August 2018</td>
</tr>
<tr>
<td>Clinical Conscientious Consideration Session</td>
<td>Doctors, nurses, therapists, health scientists and a range of other healthcare professionals</td>
<td>14 August 2018</td>
</tr>
<tr>
<td>Executive Team Conscientious Consideration Session</td>
<td>Executive Directors</td>
<td>15 August 2018</td>
</tr>
<tr>
<td>Board Seminar Conscientious Consideration Session</td>
<td>Board Members</td>
<td>16 August 2018</td>
</tr>
<tr>
<td>CHC Conscientious Consideration Session</td>
<td>Community Health Council Members</td>
<td>17 August 2018</td>
</tr>
<tr>
<td>West Wales Care Partnership Conscientious Consideration Session</td>
<td>Local authority, health, third sector and user/carer representatives.</td>
<td>21 August 2018</td>
</tr>
<tr>
<td>Equalities Groups Conscientious Consideration Session</td>
<td>Equalities/Protected Characteristics Groups representatives.</td>
<td>23 August 2018</td>
</tr>
<tr>
<td>CHC Conscientious Consideration Session (follow up)</td>
<td>Community Health Council Executive Committee Members</td>
<td>29 August 2018</td>
</tr>
<tr>
<td>Staff and Stakeholder Conscientious Consideration Session</td>
<td>Clinical and non-clinical staff and other key public and voluntary sector organisations</td>
<td>5 September 2018</td>
</tr>
<tr>
<td>Clinical Conscientious Consideration Session</td>
<td>Doctors, nurses, therapists, health scientists and a range of other healthcare professionals</td>
<td>6 September 2018</td>
</tr>
<tr>
<td>Clinical Recommendation Group</td>
<td>Doctors, nurses, therapists, health scientists and a range of other healthcare professionals</td>
<td>10 September 2018</td>
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</table>
At each session, attendees were asked to read and understand the findings thoroughly and then to conscientiously consider everything they had heard in order to robustly test and challenge the initial proposals (and underpinning modelling assumptions - for clinical sessions). This involved looking at everything in the round from Phase 1 into Phase 2. The conscientious consideration then explored what impact the findings had on the proposals and the recommendations going forward. Attendees were reminded not to give any particular weighting to any individual aspect of the analysis.

During the sessions, or independently, attendees were asked to:

- **Share their initial thoughts on the findings of the report:**
  - what the report tells us
  - whether the findings were consistent with what was heard during Phase 1
  - whether the findings reflect what was heard during the consultation
- **Consider the themes that have been identified from the report:**
  - is there agreement with the themes
  - are there any themes missing
- **Consider the findings against the original proposals:**
  - what are the implications for the three proposals
  - what changes or adaptations might be needed
  - what additional work is required to address the negative aspects/concerns expressed in the analysis
  - the innovative and credible suggestions put forward in alternative proposals
  - what was the key feedback on the fixed points
- **Review the modelling assumptions (for clinical sessions):**
- what implications the findings have on the assumptions
- Discuss any emerging recommendations:
  - for the community model
  - for hospitals

The output of each session was captured into a template or via written notes, which were collated and shared with the clinical conscientious consideration group members.

The workshop held on the 5th September provided an opportunity to engage a larger number of staff and stakeholders and in addition to a session for conscientious consideration, the morning was utilised to support independent challenge and testing of Hywel Dda UHB’s strategic thinking. Led by Mike Wagner of the Advisory Board (a global research, technology, and consulting firm helping health system leaders improve the quality and efficiency of patient care), the session focused on successful strategy design and delivery, and learning from effective examples of collaborative working which have delivered innovative results around the world.

The outputs from all conscientious consideration sessions were discussed in detail at the second Clinical Conscientious Consideration session, which was held on the 6th September. In order to inform the development of the final clinical recommendations to Board, the clinicians were asked to shape the recommendations on the basis of all the conscientious consideration, and reach a collective view on the emerging recommendations.

On the 10th September a Clinical Recommendations Group was convened to agree the Final Clinical Recommendations to be taken forward for discussion at the Public Board meeting on the 26th September.

5.8.2 The Outcomes of Conscientious Consideration

The main points resulting from the conscientious consideration are summarised as follows:

5.8.2.1 The Consultation Analysis

There was general consensus across all groups that the ORS analysis report reflected what was heard during the consultation.

There was also recognition that the case for change was widely supported in the findings, across all consultation methods.

Initial reactions to the findings of the analysis tended to centre on:
• the impact of the need for further detail in the proposals (see further detail below);
• the general confusion around language and terminology;
• the high level of responses from Pembrokeshire in comparison with Ceredigion and large parts of Carmarthenshire;
• the petition in Pembrokeshire and the strength of feeling this indicates;
• the response rate and some of the limitations to the consultation, for example the motivation of respondents;
• the tendency of respondents to over-focus on the hospitals and buildings rather than the development of the community model (see further detail below);
• the importance of transport and anxiety around distance to access emergency care (see further detail below)

There was a consensus view that the findings of the consultation were consistent with what was heard during Phase 1, in particular support for more care closer to home, the separation of planned and urgent care and the need for more joined up services; and a reiteration of the impact of travel and access, but that people are willing to travel to access specialist planned care.

5.8.2.2 Community Model

Whilst there was overall support for a community-based approach, consideration of the findings indicated some areas that would require further detailed development.

Whilst the community model itself was not within scope, the consultation did request feedback on the location of community hubs; the types of services to be delivered at community hubs; and the range of professionals and organisations that should be involved in providing health and care, and there was nonetheless a considerable amount of other associated feedback from the public. Although, it was noted that there was a relative lack of consultation feedback on prevention and early intervention, and promotion of health and wellbeing.

The perceived lack of detail in the proposals is a key consideration impacting on understanding of the potential of the community model and could explain the level of disagreement with the proposed locations and types of services. The general lack of understanding around what a ‘hub’ or a ‘community hospital’ would be and what services would be in each hub/hospital must be addressed to provide confidence in a community based model as positive alternative to traditional hospital based services. It was generally concluded that language was important and the terms ‘hubs’ and ‘community hospitals’ were unhelpful and should be avoided going forward.
To challenge this further, the notion of a ‘hub’ as a physical building was questioned as this reinforced the focus on buildings and hence did not extend the ambition of care closer to, or at home. Instead, there is a need to move away from buildings and ‘hubs’ to networks of care within a social model for health and well-being, which focuses on prevention and self-care in the first instance, but also supports a range of health and care support delivered where it best meets the person’s needs. This is underpinned by network navigators/care connectors and a range of access points including face to face contact, telephone and web interface to support the person’s journey through the system.

Changing our approach in this way will shift the focus away from community beds in buildings to supporting people in their own bed and embracing the alternatives to community ‘beds’. For example, commissioning nursing home and Extra Care beds on an as required basis, allowing a flexible response to need. New approaches also allow for alternative models of care to be put in place to mitigate the impact for those communities who challenged the distance away from the physical hub (and hospital) buildings proposed.

A number of suggestions for alternative and additional community hub locations were put forward in the consultation. Consequently, there is a need to review the approach to ‘hubs’ and their locations, in the context of the wider network of care and the particular needs and assets of individual communities and how innovative and integrated community approaches may be developed. This will require further engagement at locality level to co-produce the appropriate community solutions.

Consideration of the consultation findings highlights the need to approach this proposed move away from a reliance on community beds, with sensitivity. We have noted the strength of feeling displayed around community beds, particularly but not exclusively, associated with the proposals for Amman Valley.

The community model, based on networks of care, has to be co-designed in partnership not only with the public and staff but critically with key local partners. In order to provide integrated and seamless care in the community, the model has to be designed with Local Authority and third sector partners to deliver a whole system change which benefits the person and their community. This will also require the strengthening of commissioning arrangements with the independent sector to support more efficient care – provided when and where it is needed - so that the available capacity and community assets are maximised.

In the conscientious consideration workshops, our clinicians discussed the need to explore the key role that alternative potential partners can play, in embracing innovative community approaches to health such as the Jersey postal worker scheme as referred to in the consultation document.
During conscientious consideration, many examples were shared where locality driven initiatives are working well, but it was generally recognised that despite pockets of very good practice across the whole of the Hywel Dda UHB area, there was no single example where the whole system was working cohesively. Therefore, there is a need to build upon and upscale existing successful locality driven initiatives, models and areas of good practice, and ensure consistency of approach where relevant. It was also suggested that we should share and publicise the success stories to help build the picture of how things can be done differently and achieve positive outcomes.

It was acknowledged that current fragility of community services, and lack of permanency arrangements in both funding and staffing, impacts upon the stability of emerging community models, and confidence that there will be further investment in future. Indeed, despite efforts to communicate the intention to begin investment in the community model immediately, it was evident from the consultation analysis that this had been misunderstood. We recognise the need to clearly communicate that the community model provides the foundation to any other changes, and provide reassurance that there will be investment to enable the necessary change to happen (e.g. via the Welsh Government Transformation Fund). Furthermore, additional work is required to define the level of investment and funding shift required to deliver the proposed changes.

It was noted that some consultees raised the need to see the community model working in practice first, often physically as a pilot ‘hub’ or ‘community hospital’. There was agreement that exemplars and early implementer sites would be beneficial but also that this might serve to reinforce the focus on buildings, therefore there is also a need to prove the concept of the network of care. This may require the use of innovative methods, including virtual, to clearly communicate with the public in ways they understand.

During conscientious consideration we recognised that the repurposing of the Glangwili and Withybush sites as Community Hospitals was not fully understood. The public perception of Community Hospitals is largely based on traditional models and a far cry from the intended ambition for those sites. The aim is to maximise the potential of the repurposed general hospital sites to provide a range of services according to local needs and mindful of the overall provision across Hywel Dda UHB. These may include step-up and step-down beds to support acute admission avoidance and timely discharge, day case procedures, renal dialysis, chemotherapy and ambulatory care. There is a need to co-design these facilities and clearly outline our intentions for them. The use of the term “community” hospitals in relation to the repurposing of existing sites is seen as unhelpful going forward.

Providing clarity around the community model and how this will change our requirements for hospital based services will serve to mitigate the impact of where
buildings are located and allay concerns expressed by consultees around access to care. This will also inform future decisions associated with the hospitals model (see further below). To support this, there is a clear need to fully commit to maximising the potential for digital health and how it supports health promotion, prevention, and self-care as well as delivers innovative ways to support access to healthcare.

There is a need to clearly describe the community model, in ways the public and staff can understand, which articulates the ambition not just for more care at home and within the community closer to home, but that shifts focus towards the long term opportunities for the promotion of better health and wellbeing for future generations across Hywel Dda.

5.8.2.3 Hospital Model

There was widespread agreement during conscientious consideration that, based on the consultation findings, there was not enough support for Proposal C as a viable option and that it should therefore be discounted.

The findings related to Proposals A and B were much debated throughout conscientious consideration as the feedback to the consultation had showed mixed support for both, with no clear preferred proposal. It was therefore agreed that either could be progressed. Discussion focused around the two key differences between Proposals A and B:

- the provision of acute medicine at Prince Philip Hospital and the relevance to patient flows to Morriston Hospital;
- the number of acute hospitals and the impact this has on investment released for developing future models of care.

During the conscientious consideration it was agreed that the hospital configuration set out in Proposal B offers the best possibility of change moving forward, although recognising that the impact of the wider model cannot be fully predicted at this time. Therefore comprehensive reviews will be required in planning any service change, including our strategic ambition for the hospital configuration over time.

The elements present in both Proposals A and B, which were supported through the consultation, were the separation of planned and urgent care, but on a single site; and a new hospital for the south of the Hywel Dda UHB area in an identified location.

When considering the level of disagreement around the proposed location of a new hospital, there was a majority view that sufficient focus on the development of approaches and models to provide enhanced support to communities furthest from the main hospital services should mitigate the impact of where the centre was
located. Many argued that an effectively functioning community model, including a focus on health promotion and prevention, would reduce the reliance on hospitals and again make the location of physical buildings less relevant. This reiterates the need for investment in the community model first, and an ongoing assessment of the impact this is having on demand and patient flows. Please refer to section 5.7.3 which details how alternative proposals for locations were considered.

There were strong messages during our consultation about the removal of community hospital beds, with a particular focus on Amman Valley Hospital. We will work with our local staff and populations to design what best meets the local health and well-being needs, making best use of the available community assets, setting out clearly the key milestones and enablers to delivery. Ambulatory care can provide effective local alternatives to in-patient treatment including diagnosis, observation, consultation, treatment, intervention and rehabilitation, and our aim is to maximise this approach.

It is notable that during conscientious consideration there was a reiteration of the impact of the proposed location on two specific clinical areas, namely paediatrics and obstetrics; and patient flows to Morriston Hospital/ABMU, which was also identified frequently by consultees. There is therefore a need to undertake further modelling work with regard to Maternity and Child Health Clinical pathways to understand in detail the impacts and opportunities of the proposed hospital and community model and any potential solutions; and a requirement to continue to work closely with ABMU to ensure that there is strategic alignment across the emerging ambition of both Health Boards, as well as effective regional pathways.

The strength of feeling evident in Pembrokeshire, including a large petition, associated predominantly with the proposed removal of A&E from Withybush, was also an important matter for consideration. It was acknowledged that the perception of loss of services generates real fears and concerns that must be addressed with sensitivity. As above, delivering an enhanced community model and providing real and reliable alternatives, including an enhanced 24/7 community response and the provision of the majority of care in the locality without the need to travel to the main hospital site, should address these concerns. There must be particular effort to clearly communicate this with the residents of Pembrokeshire. Specifically, further work is required to very clearly articulate the future ambition for Withybush Hospital, what services would be provided and the benefits to the local population. The movement away from the phrase ‘Community Hospital’ is particularly relevant in this instance as it may have served to reinforce concerns around loss of services.

Whilst not within the scope of the consultation, feedback was received during the consultation with regard to Bronglais Hospital. Consideration of this feedback centred around the need to fully understand the impact of the location of a new hospital upon patient flows, and on clinical pathways. There was also a recognition
that whilst the proposal was for Bronglais to remain as a General Hospital, there should be an ambition to enhance and develop services in line with the vision of the Mid Wales Joint Committee and to enhance sustainability of services for surrounding populations.

5.8.2.4 Other Considerations

The period of conscientious consideration highlighted a range of areas requiring further development, which cut across the community and hospitals model.

- Transport and Infrastructure

The most significant of these being the need to address the impact that transport and infrastructure has on travel and access to hospital and community services within any proposed model. Whilst the impact of this was seen as universal, the additional impact on specific groups was recognised and was a particular focus when the findings were considered by Equalities Groups. In response, it was generally acknowledged that delivering the innovative solutions required to reduce this impact is not the responsibility of Hywel Dda UHB alone, and therefore that a partnership approach is required with WAST, Local Authority and third sector partners, the Welsh Government, and also the private sector. As previously stated, a common viewpoint held was that an effectively functioning community model, supported by the full maximisation of technology, should reduce the need for travel, and hence could potentially mitigate the impact of poor transport and infrastructure. Nevertheless, the need to travel to access care will never be completely removed and therefore there is a need to design and deliver travel and transport solutions as a key enabler to the proposed changes. It is also necessary to design and develop, building on continuous engagement with the communities themselves, the additional provision required to support access for those communities with the longest travel times.

Particular focus was given to public perceptions around emergency transport and concerns about distances from the proposed location of hospital services. There is a very clear requirement to communicate messages around how the role of the Paramedic has been enhanced so that treatment commences at the scene, thereby dispelling the notion of the ‘Golden Hour’. Further confirmation of the management of those conditions that are time critical and/or are already treated outside of the Hywel Dda UHB area, and how emergencies are currently managed (particularly industrial accidents) is needed in order to reassure the public of the impact of the changes. Further, there is a need to commission WAST services differently, moving away from the traditional vehicle based model to one where the service plays an integrated role across professional boundaries, building on the community emphasis, which would see for example advanced practitioners working not only for WAST but also working
jointly in primary care, out-of-hours and emergency departments as part of a rotational model. Working closely with our WAST colleagues will be an essential enabler to design and deliver the changes.

- Communication

The conscientious consideration of findings reiterated the need for clear communication, in ways that the public can understand, of the proposals for change. Despite considerable efforts by Hywel Dda UHB, it has been a challenge to communicate the complexity of the consultation and the key messages. Teulu Jones will need to be central to how change is designed and described. Associated to this, there has been a general challenge around the lack of detail in the proposals, therefore there must be focus on, again in conjunction with the public, co-producing the detailed models of care.

- Transition Planning

One of the most significant anxieties from the public related to a perception that changes were going to happen immediately, and the impact this would have on service provision. As well as emphasising that the community model will be prioritised, there is a need for clearly defined transition plans which demonstrate how changes will be phased to maintain business continuity. This will provide reassurance to the public that change will happen incrementally.

- Continuous Engagement

In addition, as has been emphasised within the report, and was evident when the consultation findings were conscientiously considered, there needs to be a firm commitment to continuous engagement and co-design so that the public and partners are involved with the final design and decisions. This will need to involve targeted engagement at locality level, and associated with specific pathways of care.

- Workforce and Resourcing

Another key consideration refers to feedback throughout the consultation surrounding workforce and resourcing. Discussion centred around:

- whether the proposed changes will have the required impact on recruitment and retention, particularly relating to the proposed location of the new hospital;
- the need for more doctors, nurses, therapists to support the community model in addition to the hospitals model;
- the need for a range of new roles and a comprehensive skill-mix;
• the need for a more integrated approach to delivering the community model, and the opportunity to work with partners for regional and joint posts across hospitals and community;
• the risk that proposals might destabilise existing staffing levels by creating uncertainty;

This will need to be addressed through an extensive workforce re-modelling, planning and transformation plan, which should commence immediately.

• Alignment with Transforming Mental Health

The recent TMH consultation, and associated model as agreed by the Board in January 2018, was raised throughout conscientious consideration, specifically the need to ensure full alignment across both programmes. The opportunities for this were referred to within the supporting documentation but it was recognised that this had perhaps not been made explicit enough during the consultation. Access issues, for people with mental health and learning disabilities, were however highlighted through the consultation. It was therefore suggested that mental health, and learning disabilities, should run throughout the whole TCS programme and not appear separately, and that opportunities for alignment, for example co-location of services, should be maximised.

5.8.2.5 Conscientious Consideration by Equalities Groups

Equalities Groups that had been engaged with during the consultation were invited to attend a specific session to consider the findings of the consultation analysis on 23 August 2018. There were 12 stakeholders in attendance, representing nine groups covering a range of protected characteristics.

There was overall agreement that the analysis report reflected what was said during the consultation. Participants emphasised some key areas, which included:

• transport and access;
• the need for further information about what services will be delivered from community hubs and hospitals, and where they will be located;
• recruitment and workforce planning;
• a recognition of the challenges surrounding Withybush Hospital

When discussing the key themes that had been presented following a review of the report, there was overall consensus amongst participants that these were the correct themes. It was, however, expressed that travel and access for people with sensory loss was not mentioned explicitly in the ‘travel and access’ theme. This will need specific consideration as we move into the next phase of the programme.
Participants were asked to comment on the proposals and there was no general consensus amongst the group, with some preferring Proposal A and others preferring Proposal B. It was however noted that Proposal C wasn’t felt to be viable due to transport and staffing issues.

Some commented on how the proposals could be strengthened for example by providing a community hub for North Pembrokeshire across all proposals, improving accessibility of services and the need to improve road and rail infrastructure whatever the proposal. Indeed, it was noted that public information to further clarify what the shift towards the delivery of more community services means, and the actual services that could be provided in the community, could mitigate existing concerns about where the hospitals are located.

Additional comments included the need for Hywel Dda UHB to involve specialist disability groups early in the design of any new facilities and at the very beginning of the planning process, through the establishment of an Access Group. It was felt that if there is going to be a new hospital, it should follow the very best practice. Similarly the importance of educating and training staff about the needs of different groups, e.g. deaf awareness training, was highlighted.

Some positive comments were received in relation to current service provision and the suggestion put forward that these may be widened in the new model, for example Rehabilitation Officer for Visually Impaired.

Finally, it was noted that there is a need to accentuate the positives of change, through regular communications with the public and key stakeholder groups.

**Responding to Equalities Impacts**

In seeking assurance around a robust equality impact assessment process, advice from the NHS Centre for Equality and Human Rights suggests posing the following questions:

- Is the purpose of the policy change/decision clearly set out?
- Have those affected by the policy/decision been involved?
- Have potential positive and negative impacts been identified?
- Are there plans to alleviate any negative impact?
- Are there plans to monitor the actual impact of the proposal?

Hywel Dda UHB is committed to continuously engaging with appropriate representative bodies and individuals to explore ways of eliminating or mitigating any identified potential negative impacts as future service pathways are designed,
developed and implemented. Mechanisms will be in place to monitor impact as we design clinical pathways following implementation of any new model in order to further inform how services need to be delivered. Continuing discussions in a frank and open manner will assist Hywel Dda UHB in meeting its duty of due regard.

Taking into account the findings of the ORS report and feedback from the Equalities Stakeholder Groups meeting on 23 August 2018, issues in relation to travel and transport, whilst being more acute for certain protected groups, reflect the impact on the population as a whole. Continuous engagement and the involvement of service users, particularly representatives from protected groups and support organisations will assist Hywel Dda UHB to explore ways of eliminating or mitigating any potential negative impacts.

In addition, many of the issues raised may be dealt with through Hywel Dda UHB’s practice of person-centred care, including the consideration of socio-economic needs, the development of individual care packages and the consistent scrutiny of patient needs along the length of the patient and service user care pathway.

It is evident from feedback received that awareness training for staff in relation to the particular needs of protected groups is an essential component of providing inclusive, equitable services. Health Board staff have access to the NHS Centre for Equality and Human Rights (CEHR) “Treat Me Fairly” e-learning package, which is mandatory training for all staff. NHS CEHR also provide an extended programme of packages including “Sensory Loss”, “Gypsy, Romani, Traveller” and “Trans” Healthcare packages with plans to develop a Learning Disability Module by April 2019 and an Age module to follow. Bespoke training may also be arranged for individual staff and teams on request.

In response to this feedback the Equality and Diversity team will actively engage with staff and produce bespoke training for teams and individuals as requested.

While the proposals may not have been universally accepted, following a preventative agenda and working towards bringing more care closer to home would reduce the incidences of people having to travel to a location further afield to access specialist and in-patient services. This would facilitate the provision of a more individualised, holistic service for patients and service users across all protected groups. Opportunities for staff development will be a key feature of future developments, working closely with staff around their career plans and individual needs.

Hywel Dda UHB will continue to work with key stakeholders, partner organisations and the people most affected in order to work towards eliminating or reducing any potential disadvantage at any stage and explore opportunities to advance equality.
The clinical recommendations, which consider and reflect the outcome of the conscientious consideration as above, can be found in section 6.

5.8.3 Alternative proposals and suggestions

A key element for consideration is any alternative proposals or suggestions put forward as part of the public consultation. A number of alternatives were proposed ranging from suggesting a small change to one of the proposals consulted on, to a suggestion for a completely different proposal.

All these alternative proposals or suggestions were reviewed and categorised as follows.

<table>
<thead>
<tr>
<th>Category</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative proposal</td>
<td>Review process undertaken – see below.</td>
</tr>
<tr>
<td>Modification to Proposal A, B or C</td>
<td>Review process undertaken – see below.</td>
</tr>
<tr>
<td>Suggestion for alternative location for new hospital</td>
<td>Proposals A, B and C were remodelled with the new location to assess impact on travel times, and patient flows. This information was shared with our clinicians as part of the conscientious consideration process.</td>
</tr>
<tr>
<td>Suggestion for alternative or additional location for Community Hubs</td>
<td>These views will be considered as we develop the community model. Alternative locations will be tested using patient flow and travel time analysis and reviewed as part of the whole proposed network of community provision.</td>
</tr>
<tr>
<td>Proposal or suggestion outside the scope of the consultation</td>
<td>These were mainly concerning Health Board boundary changes and no further action taken.</td>
</tr>
<tr>
<td>Suggestions already within our proposals e.g. enhance the use of technology (telehealth, telemedicine), invest in community services</td>
<td>Already covered within our proposals, no further action taken.</td>
</tr>
<tr>
<td>General suggestions around the community model, hospitals configuration, infrastructure and recruitment</td>
<td>These suggestions will be considered as we develop the future models</td>
</tr>
</tbody>
</table>

A log of the alternative proposals and suggestions is included in annex D. The log shows the source of each proposal e.g. Consultation Response, Public Drop-In, Staff Focus Group etc. The log also provides the rationale for the categorisation and the proposed action required.

The categorisation and proposed actions were reviewed and approved by Hywel Dda UHB’s Executive Team on 29 August 2018.
To assess the suggestions categorised as alternative proposals or modifications to Proposals A, B or C we first checked whether the proposal had been considered during the Options Development process (please see section 4.4 above).

This review highlighted that there was only one alternative proposal that had previously been considered and that was to maintain the status quo. The status quo was ruled out at an early stage of the options development process and so no further action was taken.

For the remaining alternative proposals and modifications, the same process that was used in the options development phase was followed.

This process is as follows:

1. The Options Development Action Group (ODAG) was re-convened to review the proposal and undertake a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis. ODAG is formed of clinicians from a range of disciplines, including hospital doctors, GPs, nurses, therapists and healthcare scientists. If the ODAG deemed the proposal not viable, following the SWOT analysis, it was not pursued further. If ODAG believed the proposal to be worthy of further assessment and consideration, it would proceed to step 2.

2. A range of modelling and analysis would be undertaken. This would include:

   a. Modelling of activity, capacity and patients flows
   b. Travel time analysis
   c. Testing of the proposed build zone for a new hospital
   d. High level financial modelling and affordability assessment
   e. High level view on workforce implications

3. This suite of analysis and information (SWOT, modelling and analysis) for the proposal would then be taken forward to step 4.

4. A scoring exercise would be undertaken to assess the proposal against the criteria developed during the Options Development phase. The same scoring methodology would be used as was used previously. To be considered further the proposal would have to score equivalent to or more than the proposals taken to public consultation

5. For any alternative proposals that scored equal to or more than the proposals consulted on, an Equalities Impact Assessment would be undertaken.
6. Any alternative proposals that remained under consideration would be presented to our Executive Team in September. The Executive Team would take a view on whether any proposal that reached that stage of the process presented as a viable option. If a proposal was deemed to be a viable alternative to the three proposals consulted on, there were two potential scenarios: if the alternative proposal was broadly the same as one of the proposals consulted on but with some adjustments this could be adopted without the need for further consultation; if, however, the alternative proposal was radically different to the proposals consulted on there may be a requirement for further public consultation before it could be adopted.

Eleven alternative proposals or modifications were considered using this process. They were all reviewed by 12 members of the Options Development Action Group, who each undertook a SWOT analysis. This can be viewed at annex E.

The outcome of this exercise was that although none of the alternative proposals or modifications were deemed to be viable as new proposals, all elements of these suggestions were considered during conscientious consideration. The SWOT analysis was reviewed by the Executive Team on 12 September 2018.

In addition to the ODAG SWOT analysis the Health Professionals Forum also reviewed all the alternative proposals and modifications as part of their conscientious consideration. Their written feedback stated “Clinicians did not consider that the ‘Alternative Proposals,’ communicated in the consultation, were clinically viable or financially sustainable”.

In summary, although many useful suggestions were received, all of which were considered as part of the conscientious consideration, none of the alternative proposals or modifications to the proposals consulted on were assessed as being viable, although have had a key place in informing the recommendations.

5.8.4 Consideration of alternative locations for proposed new hospital site

As noted above, several alternative locations for the proposed new hospital site were put forward during the consultation.

These were:
- Carmarthen Show Ground
- Llanelli
- Cross Hands
- Newcastle Emlyn
- Canaston Bridge
- Haverfordwest
The initial modelling during the Options Development Phase looked extensively at population density and travel times to assess the location that would give best access for the majority of our population. With the new hospital in the proposed “zone” (between Narbeth and St Clears) and Bronglais Hospital also providing Accident and Emergency services, 93% of the population can access an emergency department (by car) within an hour. This recognises that, as now, some people living to the East of the Hywel Dda Health Board area will go to Morriston Hospital.

Although the “zone” was supported as providing the best access for the majority of people it was felt important to assess and test the suggested alternative locations. Therefore additional travel analysis was undertaken to inform the conscientious consideration. The additional modelling undertaken can be seen in annex F.

First population density was re-looked at as a reminder of how the population is spread across the Hywel Dda area. Drive-times and locations were then mapped from Lower Layer Super Output Areas (LSOA), which is the smallest population collection that can be used for population analysis. The travel times were analysed to the suggested locations based on optimistic and pessimistic as well as best guess estimates – this was based on historic data via google mapping, and extracted from the population weighted centroid of each LSOA. This is a more granular approach compared to the earlier modelling which used GP practice locations and registers, and allows for a better understanding of potential flows.

The longest drive times were looked at particularly to access Accident and Emergency care for each location, including the current configuration and three points within our proposed “zone” (Narberth, St Clears, Whitland) for comparison.

The analysis also looked at the potential impact of each location on Morriston Hospital and Bronglais General Hospital i.e. the percentage of population increase or decrease that would be closest to Morriston or Bronglais Hospitals compared to the status quo. In this context closest refers to drive time not miles. The full detail can be seen in annex F but a summary is shown in table below:

<table>
<thead>
<tr>
<th>Location</th>
<th>% within 60 mins (average drive time)</th>
<th>% within 60 mins (pessimistic drive time)</th>
<th>Potential impact on Morriston and Bronglais (NB. Closest = drive time not miles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status Quo</td>
<td>100</td>
<td>100</td>
<td>Currently 64% of the population closest to either Withybush (34%) or Glângwili (30%), with 13% closest to Bronglais. 23% closest to Morriston.</td>
</tr>
<tr>
<td>Narberth</td>
<td>100</td>
<td>99</td>
<td>57% increase in population with closest A&amp;E = Morriston</td>
</tr>
<tr>
<td>Location</td>
<td>Population 100</td>
<td>Population 99</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>St Clears</td>
<td>100</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Whitland</td>
<td>100</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Carmarthen Show Ground</td>
<td>100</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>Llanelli</td>
<td>69</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Cross Hands</td>
<td>87</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Newcastle Emlyn</td>
<td>84</td>
<td>81</td>
<td></td>
</tr>
<tr>
<td>Canaston Bridge</td>
<td>100</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Haverfordwest</td>
<td>100</td>
<td>96</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Increase in population</th>
<th>Closest A&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Clears</td>
<td>28%</td>
<td>Bronglais</td>
</tr>
<tr>
<td>Whitland</td>
<td>20%</td>
<td>Morriston</td>
</tr>
<tr>
<td>Carmarthen Show Ground</td>
<td>57%</td>
<td>Morriston</td>
</tr>
<tr>
<td>Llanelli</td>
<td>151%</td>
<td>Morriston</td>
</tr>
<tr>
<td>Cross Hands</td>
<td>97%</td>
<td>Morriston</td>
</tr>
<tr>
<td>Newcastle Emlyn</td>
<td>69%</td>
<td>Morriston</td>
</tr>
<tr>
<td>Canaston Bridge</td>
<td>66%</td>
<td>Morriston</td>
</tr>
<tr>
<td>Haverfordwest</td>
<td>93%</td>
<td>Morriston</td>
</tr>
</tbody>
</table>

The outcome of this exercise was that none of the suggested alternative site locations proved to be a better option that the proposed zone in terms of access for the whole population. It was also noted that the more granular modelling showed that the outputs of the previous modelling had been overly pessimistic.

Pending Board decision to move forward, there will be a need to undertake a further analysis and modelling, as part of a formal feasibility study, to assess in more detail the various potential locations within the zone as they do have varying levels of potential impact on flows to Morriston and Bronglais Hospitals. The modelling will be further informed and refined as the hospital model is developed and clinical specialty specific flows can be analysed.
5.8.5 Formal Response from Hywel Dda CHC

Hywel Dda Community Health Council (CHC) considered the ORS independent consultation analysis to inform a formal response as part of their statutory duties around service change in their role as the patient/citizen voice. The CHC have been closely involved with the process throughout engagement and consultation and were generally reassured that Hywel Dda UHB has followed relevant guidance to involve and engage people in the consultation through a variety of methods, whether face to face, through traditional media or through social media.

The CHC report that where issues or suggestions were raised, the Heath Board was generally receptive and responsive, for example, in responding to requests for additional public drop-in events and improving availability of consultation materials in key areas where people accessing NHS services would tend to be.

According to the CHC’s observations, where people wanted to have in-depth discussions, often with senior clinicians and managers about the proposals, this was facilitated, with Health Board staff being sincere in their approach to talking with the public and explaining different aspects of the proposals. However, whilst Hywel Dda UHB’s efforts were recognised, the CHC noted that too many people seemed unaware of the consultation or ways of contributing. There was a clear imbalance between the numbers of people signing petitions and the numbers of people who completed questionnaires or attended drop-in events.

Hywel Dda UHB accepts the CHC’s comment that the timescales during the design phase of the consultation sometimes challenged members’ ability to consider and feedback, and acknowledge the expectation that future engagement and consultation strikes a better balance between pace and thoroughness.

The formal response notes the CHC’s concern around the overall complexity that the consultation sought to discuss and the ambiguity around what services might or could look like, particularly around what community services, community hospitals and community hubs might deliver. The report notes that Hywel Dda UHB is obliged to engage further with the public and consider further consultation on more specific topics as more concrete detail arises.

The CHC formal response summarises the main messages from the consultation, and their own conclusions, along with a series of recommendations.

In summary, whilst noting that the case for change is strong, the way forward will be complex and there are concerns amongst the public around access to care, as well as evidence from partners on the impact of implementing the proposed changes.
Therefore the CHC conclude that until more work is done to illustrate how each component of a new system could operate more clearly, the public cannot be expected to accept change where there is concern and opposition.

The overall view of the CHC is that Hywel Dda UHB should continue to plan for system-wide change, however that the consultation has not given Hywel Dda UHB a mandate to take final decisions at this point, as much more needs to be done to explore the feasibility and safety of different (and controversial) elements within the proposals. This would allow for further engagement and consultation with the public over the coming years with a more specific focus.

To this end, the CHC have not stated support for any single proposal due to the fact that preference for particular proposals tended to be locality based and their role is to represent the views of people from all three counties. Instead the CHC ask Hywel Dda UHB to adhere to certain principles as part of the decision making and planning, with further opportunities for public involvement as draft plans develop.

The recommendations are highlighted below under the headings used by the CHC:

**A&E Closures**

**Recommendation 1:**
For all services Hywel Dda UHB is expected to ensure that no service change can take place which would lead to care that was less safe or of a lesser quality than existing services.

**Recommendation 2:**
Hywel Dda UHB is expected to assure the public that no final decisions on removing specific services will be made until a fuller case is developed.

**Recommendation 3:**
Hywel Dda UHB is expected to engage and where necessary consult further with the public on specific changes as a clearer picture of how new services would run emerges.

**Primary Care**

**Recommendation 4:**
Hywel Dda UHB is expected to ensure that plans are in place that put GP practices in a better long-term position as systemic change is developed.
Transport

Recommendation 5:
Hywel Dda UHB is expected to make a clear commitment to placing transport at the heart of its strategic plans with a willingness to innovate, a clear understanding of need, and appropriate funding to meet those needs. Transport providers including third sector providers need to be closely involved with planning.

Community Focus

Recommendation 6:
Hywel Dda UHB is expected to prioritise the development of community services given the strategic importance of this change to making further hospital changes.

Recommendation 7:
Hywel Dda UHB is expected to demonstrate how it will achieve better integration with social care, the third sector and carers, working with them to help develop more detailed plans.

Recommendation 8:
Hywel Dda UHB is expected to show how it will monitor quality and safety experiences of people’s care comprehensively as care moves away from traditional hospital settings and into the community.

Recommendation 9:
Hywel Dda UHB is expected to demonstrate a clearer picture of how community services would work for the public, including the possible early development of a community hub to help achieve this.

Workforce

Recommendation 10:
Hywel Dda UHB is expected to develop workforce plans that illustrate how the changes would be supported by enough appropriately qualified staff to ensure services would be sustainable and of high quality.

Future co-production and flexibility in implementation

Recommendation 11:
Hywel Dda UHB is expected to make a clear commitment to continue a co-productive approach and build flexibility into its planning.
County Commentary

Recommendation 12:
Hywel Dda UHB is expected to give due consideration to the alternative proposal put forward and note the concerns of people in relation to Prince Philip and Amman Valley Hospitals.

Recommendation 13:
The CHC believe Hywel Dda UHB should give due consideration to Lampeter as a community hub venue and that the strategic future of Bronglais hospital needs to be set out in a detailed plan which shows Ceredigion people (whole catchment area of mid Wales) and those in neighbouring counties (Powys and Gwynedd) how the hospital will develop in coming years.

Recommendation 14:
The CHC feel that Hywel Dda UHB needs to carefully consider healthcare equity across all areas as it looks at developing draft plans further, linking with Conclusion 1 around maintaining safety and quality through service change.

Recommendation 15:
The CHC think that Hywel Dda UHB should consider developing a community hub in the north west of Pembrokeshire.

Risks of large scale change

Recommendation 16:
The CHC believe that Hywel Dda UHB needs to show how delivering such large scale change will not impact on its day-to-day ability to manage current and future problems that may arise.

Cross-border NHS Care

Recommendation 17:
Hywel Dda UHB is expected to be mindful of the importance of cross border issues as it develops its plans, for its own residents and those living in other health board areas who could be affected.

Mental Health Services

Recommendation 18:
Hywel Dda UHB is expected to show clear linkages with the “Transforming Mental Health” implementation and ensure that Transforming Clinical Services adds value to this process.
The full Hywel Dda Community Health Council’s Commentary on the “Transforming Clinical Services” Consultation available in annex G.

6. Recommendations

A significant amount of feedback was received through the public consultation process and subsequently independently analysed. This has been conscientiously considered by clinicians, staff and key stakeholders, alongside everything that has been learned and understood throughout Phases 1 and 2 of the TCS programme.

The three proposals presented to the public were the starting point for a conversation that will continue over the years to come. It was clear that, depending on the findings, the proposals could be modified or adapted, and the public were invited to suggest additional proposals. Therefore, through the consultation, new ideas and views were welcomed, and useful insight and challenge was considered.

The recommendations reflect the four guiding principles – to provide health and care services which are Safe, Sustainable, Accessible and Kind – in line with our original ambition.

The recommendations are the collective view of our clinicians. They reflect:

- A recognition of the need to respond to the case for change
- A response to what we have heard in the public engagement and consultation
- The views expressed by clinicians, staff and stakeholders in conscientious consideration of the consultation feedback sessions
- The outcome of a debate in a session with clinicians on 6 September 2018, and finalised and agreed in a follow-up session on 10 September 2018.

**Recommendation 1**

The Board is requested to approve the development and implementation of a community model, based on an integrated social model for health and well-being (the model), at pace. This will be a long term commitment focused on prevention, well-being, early intervention and help build resilience to enable people to live well within their own communities. In addition, the Board is also requested to:

- Commit to stabilising and investing in the model, to build on and scale up local and cluster led initiatives and services which are already provided.
- Identify and develop opportunities for local people to be able to see the model working in practice, with specific consideration to the geographical areas highlighted in the consultation response as gaps in current provision.
• Demonstrate real commitment to the model by resolving current uncertainty caused by temporary funding and short / fixed term contracts, which stifle development of and confidence in this model.

• Work with local people to design together how the model will work in their area, to ensure that it is fit for future generations and beyond. This will include clearly describing what is meant by integrated networks, moving away from the term “Hub”; enabling help and support to be accessed in a variety of ways including both face to face and virtually.

• Commit to concentrating on early co-design of the model in Pembrokeshire, in response to the strength of feeling expressed throughout the consultation in terms of a loss of services, with particular focus on an enhanced 24/7 community response.

• Commit to a whole system approach to the model where primary and secondary care are not seen in isolation but work together to provide seamless care for local people.

As the model develops the demand on our hospital services should reduce enabling resource to be released from hospital-based care to community-based care. We anticipate early funding via the Welsh Government Transformation Fund to better equip our services to address 5 priority areas to enable delivery of the model:

- Improving the health of our population through prevention, starting and developing well, living and working well; aging and dying well
- Seamless locality-based care, which is consistent across different agencies
- How technology can provide care round the clock, supported by joined-up community services
- Changes to the way we work and the systems we use to ensure organisations work well together
- Supporting our different workforces with change and development

**Recommendation 2**

The Board is requested to approve the development of a plan for the existing Community Hospitals, working with local communities. This plan will be focussed on the provision of ambulatory care including out-patient services, diagnostics, treatment, observation, rehabilitation and end of life care. In addition the Board is also requested to:

• Address the concerns regarding the removal of community hospital beds, working with local people to explore the potential for a range of different types of beds within the local community, whether in hospital, at home or another setting, built around the needs of the person.
• Develop a transition plan where any change in the provision of community hospital beds takes place in a phased way and takes into account the development and impact of the proposed model.
• Support the development of a robust commissioning model, including independent and third sector provision, based on local need and demand.

We heard a strong message during our consultation about the removal of community hospital beds, with a particular focus on Amman Valley Hospital. We will work with our local staff and populations to design what best meets local health and well-being needs, making best use of the available community assets, setting out clearly the key milestones and enablers to delivery. We will take the learning from the Ceredigion Community Model where traditional Community Hospital beds are being replaced with a commissioning approach which responds flexibly to local need.

Ambulatory care can provide effective local alternatives to in-patient treatment including diagnosis, observation, consultation, treatment, intervention and rehabilitation, and our aim is to maximise this approach in our existing Community Hospitals.

**Recommendation 3**

The Board is requested to approve that proposal C is discounted as the separation of planned and urgent care on different sites was not supported.

There was widespread agreement during conscientious consideration that, based on the consultation findings, there was not sufficient support for proposal C as a viable option and that it should therefore be discounted. The separation of planned and urgent care was widely supported, however this was caveated on the basis that planned and urgent care continued to be provided from the same site.

**Recommendation 4**

The Board is requested to approve a modification of the remaining proposals for delivering hospital services, to include:

- A new urgent and planned care hospital in the South of the Hywel Dda UHB area.
- Acute hospital services retained and developed in Bronglais General Hospital.
- Acute medicine retained at Prince Philip General Hospital
- A repurposed Glangwili General Hospital and Withybush General Hospital offering a range of services to support the social model for health and well-being (the model), designed with local people to meet their needs.

Whilst this proposal gives us the best possibility of change moving forward, the full impact of the delivery of the model and the new urgent and planned care hospital cannot
be fully predicted, therefore comprehensive reviews will be required in the planning of service change. This will ensure we are responsive to the impact of patient demand and flow, as well as staff working conditions and preferences. The preferred hospital model will involve review of all acute service pathways at all hospitals, including acute medicine, to ensure we make best use of the resources available to us.

In addition, the Board is requested to:

- Develop a long term plan that enables the delivery of acute medicine over time to be tested and challenged, and to be responsive to demand and patient flows associated with the proposed changes.
- Develop a transition plan to transfer emergency and urgent services from existing General Hospitals in a safe and sustainable phased way, dependent on the development and impact of the model and the new Urgent and Planned Care Hospital.
- Ensure continued close working with ABMUHB in order to align the developing Health Strategy with ABMUHB's developing Clinical Strategy, ensuring a focus on maximising opportunities for effective regional pathways.
- Commit to a focussed piece of work on clinical pathways to model the impacts and opportunities of the new hospital configuration and community model for Maternity and Child Health. This will examine a range of options which will ensure consultant-led obstetrics, midwifery led care, acute paediatrics and neonatal care are maintained across Hywel Dda.
- Guarantee complete alignment with the requirements of the Transforming Mental Health Programme to ensure mental health and learning disability assessment and treatment units are provided at the new urgent and planned care hospital, with fully integrated mental health and well-being services in the community.
- Commit to realising the ambition of the Mid Wales Joint Health & Social Care Committee, recognising the strategic importance of Bronglais Hospital in the sustainable delivery of services for the populations of Ceredigion, Powys and South Gwynedd.

We recognise that we cannot deliver our preferred hospital model in isolation as it both impacts upon and provides opportunity beyond Hywel Dda UHB boundaries. It is therefore imperative that we plan jointly with partners, across regions and Wales.

There are particular challenges to providing safe and effective maternity and child health services across a large geographical area with a relatively small population size. Ensuring that staff can develop and maintain their competence may need to include rotation to other centres, network arrangements and use of technology. There is specific guidance around the number of births required for a viable obstetric led maternity unit therefore changes to flows in the new model could have major impact. We will work with
our clinicians and staff to better understand the issues and co-design solutions to minimise any impact.

The TMH Consultation feedback questioned why consideration was not given to the co-location of the proposed Centralised Assessment and Treatment Units and that this option should be considered should an opportunity present itself. TCS is just such an opportunity, to further strengthen the integration of Physical and Mental health care within our communities and the new Urgent and Planned Care Hospital. The new urgent and planned care hospital will enable the provision of Specialist Inpatient Mental Health & Learning Disabilities Services on the same site in order to support a range of needs. These services will include the centralised Assessment and Treatment provision alongside the Psychiatric Intensive Care and Low Secure care. This will ensure the provision of a modern purpose built MHLD Inpatient Unit as part of an integrated model of care to provide for the assessment and inpatient treatment of our population across the age span. This future provision will be further supported by the development of an enhanced collaborative community model of care which will strengthen and deliver co-located care to our communities promoting positive mental wellbeing. These principles are very much aligned within the TMH CONNECT vision of Community, Open access, Needs led, Nothing about us without us, Engagement, Collaboration and Timely help and support.

**Recommendation 5**

The Board is requested to approve the progression of a proposed new Planned and Urgent Care hospital on a single site through the business case process (Five Case Model). The Board is also requested to:

- Progress consideration of location options within the defined new hospital zone, between Narberth and St. Clears, through a formal feasibility study and options appraisal to robustly consider all potential impacts.
- Work with local people to develop models to provide enhanced support to those communities furthest from main urgent care and hospital services.
- Consider the impact and opportunities a new hospital in the south of the Hywel Dda UHB area would provide to Bronglais General Hospital and the population of mid-Wales.
- Develop a plan for the approach to managing emergency conditions which are time-sensitive.

Through the consultation we heard concerns about the location of the new hospital site within the proposed zone, and consultees suggested a number of alternatives. There are public concerns about travel times to access emergency care and clinical concerns about the impact of potential locations on patient flows and staff availability. In response to this feedback, further travel analysis was undertaken, to include consideration of the alternative sites, and we determined that the proposed zone for the new hospital
provided the best access for the Hywel Dda population. The feasibility study will take account of these concerns and use detailed modelling to assess potential impacts of location options within the identified zone.

We know that there will be some people within our population who will have longer travel times to the new hospital zone, and we have identified the areas that will have the longest journeys. There are several potential approaches that can be put in place to ensure support to these areas e.g. specific WAST response plans, volunteer first responders. We need to respond particularly to the overwhelming feedback from Pembrokeshire residents around their concern about distance to main hospital services, in particular A&E, and therefore will work with local people, WAST and other partners to explore all clinical models for supporting our population in more remote and coastal areas.

Our modelling of patient flows to date, suggests that the siting of the new hospital, within the zone, will have an impact on some patient flows effectively extending the BGH catchment area to the south. BGH will function as part of a network within Hywel Dda UHB and across neighbouring Health Boards. There are specific opportunities resulting from our secondary care services being provided on fewer sites, enabling staff rotation and outreach (which may be physical or virtual) from the new hospital to support BGH.

We must respond to the anxieties expressed in the consultation and clearly explain the emergency response requirements around time sensitive emergency conditions such as ST Elevation Myocardial Infarction (STEMI), stroke and sepsis and articulate our plan for managing these, particularly in areas furthest from an emergency department.

**Recommendation 6**

The Board is requested to approve development of a plan to redesign the remaining main hospital sites, working with local people, to maximise the range of services and support available aligned to the proposed model, and a new Urgent and Planned Care Hospital. The Board is also requested to:

- Commit to working closely with Local Authorities, Third Sector partners, and other agencies to develop and deliver a plan for provision of seamless care and support at these hospitals.

Our aim is to maximise the potential care and support at the repurposed Glangwili and Withybush sites to provide a range of services working with local people to meet their needs, whilst being cognisant of the overall provision across Hywel Dda UHB. These may include step-up and step-down beds to avoid admission to the main urgent care hospital and timely discharge, day case procedures, renal dialysis, chemotherapy, investigations, out-patient services and ambulatory care.
Effective partnership working with Local Authorities, Third Sector and local communities is essential to the success of our proposed social model for health and well-being.

Recommendation 7

The Board is requested to approve the development of a detailed plan to address the significant concern heard during the consultation regarding access, travel, transport and infrastructure, ensuring a focus on exploring innovative approaches to accessing care and support. The Board is also requested to:

- Engage with the Regional Transport Group to contribute to the development of the Strategic Transport Plan to consider the opportunities which developments in road and rail infrastructure could provide for both staff and public travelling to or visiting our future health and care services.
- Develop a plan to commission community access solutions, building on and scaling up existing successful models.
- Engage specifically with local equality groups to ensure consideration is given to the particular access needs of people with protected characteristics and those most vulnerable in our population.
- Work closely with WAST to commission Ambulance Services that are not exclusively based on the conventional vehicle based model, which better support the delivery of services within the community, and focus on accessibility for our whole population.
- Formally state Hywel Dda UHB’s support for provision of 24/7 Emergency Medical Retrieval and Transfer Service (EMRTS), Cymru inter-Hospital Acute Neonatal Transfer Service (CHANTS) and continuation of 24/7 responsive Wales and West Acute Transport for Children (WATCH) services.

We need to think more broadly about access to services, using technology to support access points in or close to people’s homes. This reduces the need for travel to physical locations further from home. That said, transport and travel were major concerns voiced in the consultation particularly in relation to urgent care in our more rural areas, and therefore we need to work with local people to design services together to meet their needs.

There are many existing good practice examples of access initiatives, for example WAST working with us in new ways such as the Advanced Practitioner rotational model working with Primary Care out-of-hours service and within the community.

Recommendation 8

The Board is requested to approve the development of a plan to maximise the use of technology as a key enabler to the delivery of the proposed model underpinned
by secure IT infrastructure with sufficient back-ups, so that patient data is safe, timely and secure. The Board is also requested to:

- Commit to ensuring that digital technology drives improvement and efficiency, and changes the way people can access and engage with services and manage their own health and wellbeing.
- Develop a fully integrated information system which joins up community health care and social care records, so that all staff working in community settings can appropriately share information, with the aim of people no longer needing to repeatedly explain their individual circumstances and medical history on numerous occasions.

Maximising the use of technology will be a major enabler of our recommended model. This includes telehealth, telemedicine, exploring use of home monitoring, apps and wearables, as well as technological solutions to support our staff in their work.

**Recommendation 9**

The Board is requested to approve the development of a workforce redesign and transformation plan – starting now and forward planning – to enable delivery and sustainability of the future model. The Board is also requested to:

- Commit to explore innovative new roles including joint roles that span services, regions and organisations.
- Work closely with education and training providers to confirm the training requirements to deliver the new model along with clear educational lead in times.
- Develop a recruitment strategy which addresses the potential impact on recruitment and retention of staff, to ensure sustainability both in the short and long term.
- Commit to a process whereby staff co-design the future workforce needed to deliver the proposed model.
- Develop an Organisational Development strategy to support the organisation and individuals through transition to the future model.

Through the public consultation we heard some scepticism about our ability to staff and resource the new model. We must clearly articulate our workforce strategy and plan, including opportunities for our current staff, potential for regional and joint posts, innovative new roles, training requirements, recruitment and retention.

**Recommendation 10**

The Board is requested to reaffirm its commitment to continuously engage and support co-production between staff, and local people, partner organisations and other interested parties with a particular focus on engagement and co-design with
those most vulnerable in our population, and those with Protected Characteristics, as set out in the Equalities Act (2010). This includes the co-design of integrated local care and support, clinical pathways and innovative ways of working together.

Through the TCS programme we have heard from our staff, clinicians, patients, the public and our partners that they have valued contributing to the process. Their input has been invaluable and has helped us to shape our proposals and recommendations. We want to build on this great start and continue this open dialogue and partnership approach as we go forward. It is recognised that further consultation may be required in the future for specific services.

**Recommendation 11**

The Board is requested to approve the further development of all recommendations into the draft Health Strategy for consideration at the Public Health Board meeting on 29th November 2018.

Hywel Dda UHB must set out the direction of travel in clear terms in order to commence the process of business case development and clinical pathway design. Final decisions are dependent on the successful establishment of a full business case, which is subject to a Welsh Government decision.

Further definition and detail for all recommendations, and associated pathway design, will be developed through continuous engagement with staff, the public and key stakeholders, and in discussion with Hywel Dda Community Health Council including a discussion on areas that could potentially require further consultation in the future.
8. Programme approach for developing the Health Strategy

This section provides a brief overview of our proposed programme approach to developing the Health Strategy, subject to Board approval of the consultation closing report and clinical recommendations. There is a short period of time to develop the draft strategy in readiness for the Board meeting on 29 November 2018, as outlined in the timeline below:

**Timeline to November 2018**

The programme will continue to be overseen by the Design Steering Group (DSG), which reports directly to the Health Strategy Committee (HSC). The programme will continue to be supported by the TCS Team, which is made-up of the Transformation Director and a small team of Programme and Project Managers, who will lead on co-producing the design of the care models associated with Hywel Dda UHB’s strategy.

The Programme Team are directly leading on several workstreams relating to strategy development which include the community and hospital models. Integrated Medium Term Plan Review Panels have been established, chaired by the CEO, to “check and challenge” the development of Service and Directorate 3 year plans ensuring that they reflect the delivery of the health strategy in the early years.

In addition, the workstreams will be cognisant of the equality issues raised throughout consultation and how these will be addressed, as well as maximising wider opportunities for continuous engagement with protected characteristic groups and those most vulnerable in our society to influence future models of care.

The programme has identified a number of associated activities outside of the direct leadership of the programme that are led by identified Executive Directors, and the TCS Team are providing links to these groups and activities to help provide further
project support. This includes links to the Director of Planning and Performance to ensure the programme is cognisant of the work of the Regional Planning Committee, ARCH and the Mid Wales Joint Committee, and that all outputs feed into Hywel Dda UHB’s planning process. Additionally, the programme will link with the Director of Partnerships and Corporate Services on all relevant partnership work including the Regional Partnership Board, the West Wales Care Partnership and the Swansea Bay City Deal Joint Committee, and with the Director of Public Health to ensure alignment of the 20 year population health ambitions with the 10 year clinical strategy.

9. Annexes

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10. Appendices

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Appendix 1 – Equalities Impact Assessment Screening

Screening (stage one)

Stage one of the EqIA is the screening stage that tests the relevance of proposals to meeting the duties of the Equality Act 2010 and in relation to the potential impact of proposals on individuals and communities on the basis of equality, human rights and Welsh language. Evidence gathered at this stage identifies whether there is a need to proceed to Full EqIA.

The screening stage identified the following information in relation to protected characteristics:

**Age:** Hywel Dda has a higher proportion of people aged 75 years and older compared with the Wales average, and life expectancy for both males and females is longer than it is in Wales overall. Projections suggest that population ageing will continue, while our younger age groups will remain static or marginally decrease in number. Implications for our health and care services include, but are not limited to:

- A projected decline in the working age population, which will affect the capacity of our health and care workforce at a time of rising demand for care from our ageing population;
- A greater need for more support of older people with chronic, complex and often multiple conditions and from age-related conditions such as dementia;
- A projected increase in the number of hospital admissions among older people because of a fall;
- A projected slight increase in the percentage of working-age adults self-reporting health-damaging lifestyle behaviours (e.g. diet, overweight and obesity).

**Disability:** Healthy life expectancy and disability-free life expectancy are rising more slowly than life expectancy in Hywel Dda, meaning people are living longer but with increased levels of illness and disability. Implications for our health and care services include, but are not limited to:

- A projected rising number of people living with dementia;
- A projected rising number of people living with moderate or severe learning disabilities, especially in our older age groups.

**Sex:** Women live longer than men in Hywel Dda; life expectancy at birth for women is age 82.7 years, which is approximately three years longer than men whose life expectancy at birth is 78.9 years. Certain health conditions are more common among men in Hywel Dda, namely Type 1 and Type 2 diabetes. Women have much higher rates of disability than men, especially at older ages and have higher levels of
morbidity from poor mental health (Health Knowledge, 2016). Implications for our health and care services include, but are not limited to:

- Sex-specific service planning and delivery and public health interventions

**Gender reassignment:** There are no Hywel Dda-specific data for gender reassignment. However, data for Wales reveals that many transgender people consider transitioning or do transition in middle to later life, though age at disclosure of transgender identity is getting younger (Welsh Government Action Plan to Advance Equality for Transgender People, 2016). Implications for our health and care services are informed by UK research (Trans Mental Health Study, 2012) and include but are not limited to:

- Potential for transgender people to perceive their care as being negatively affected by their transgender identity

**Human rights:** There are no Hywel Dda-specific data for human rights. However, there is promising evidence of the care and treatment of older people in hospital, but with a number of areas for improvement and variability in the implementation of dementia-friendly care and initiatives. The right to family life might arguably be the most relevant of the human rights in the context of our proposals. Implications for our health and care services include, but are not limited to:

- Changes to the locations of services which may impact on the family life of our service users and staff, particularly if travel times require them to be away from family members for longer lengths of time.

**Pregnancy and maternity:** There are lower rates of live births and of infant mortality (i.e. the death of an infant under one year of age) in Hywel Dda compared with the Wales averages, and the rate of low birth weight babies is similar to that nationally. Rates of breastfeeding at birth are higher than the Wales average. The average age of mothers continues to rise which is important because older women are more likely to have pregnancy complications such as gestational diabetes (diabetes during pregnancy) and premature birth. Implications for our health and care services include, but are not limited to:

- Increased demands from high risk pregnancies and pregnancy complications;
- Treatment decisions during pregnancy and breastfeeding;
- Respect for breastfeeding in public spaces;
- Protection of staff on the grounds of pregnancy and maternity.

**Race:** The Hywel Dda population is composed of only 2 per cent of people who identify themselves as of Black and Minority Ethnic (BME) origin, though since these data were collected (for the 2011 Census) there has been inward migration of people from other
parts of the EU and of refugees and asylum seekers from other parts of the world. Implications for our health and care services are informed by UK research (Parliamentary Office of Science and Technology, 2007) and include but are not limited to:

- BME groups generally have worse health than the overall population;
- BME groups have lower access to hospital care and lower rates of smoking cessation compared with White British groups;
- BME groups are more likely than White British groups to report dissatisfaction with NHS services.

**Religion or belief:** There are no Hywel Dda-specific data for religion and belief. Religion and belief play an important role in how people manage stressful life events such as ill-health and can be linked to issues including diet, fasting, medications, views on organ donation and transplantation, and times of day when people wish to pray. Implications for our health and care services include, but are not limited to:

- Poorer reported health among certain religious groups (e.g. Muslims);
- Opportunities for religious observance for staff, patients and the public;
- Choice of gender of staff.

**Sexual orientation:** There are no Hywel Dda-specific data for sexual orientation. A British survey has found that lesbian, gay and bisexual (LGB) employees were more than twice as likely to be bullied and discriminated against as heterosexual employees in the workplace, and that in England LGB people have poorer physical and mental health outcomes than heterosexual people (Equality and Human Rights Commission, 2012). Implications for our health and care services include, but are not limited to (Rapid Response Service, 2014):

- Barriers to lesbian, gay and bisexual (LGB) persons accessing health care services including perceived or real negative attitudes and lack of knowledge of LGB peoples’ needs:
- Issues around disclosure of sexual orientation and, in turn, the delivery of care that is appropriate to needs.

**Welsh language:** The proportion of Welsh speakers in Hywel Dda (37%) is considerably higher than in Wales overall (19%), and at a county level rates are highest in Ceredigion (47%) and lowest in Pembrokeshire (19%) (Carmarthenshire 44%) (West Wales Area Plan 2018/2023). As many Welsh speakers are also fluent in English, the language barriers which they encounter in healthcare often appear invisible to service providers, which may jeopardise the health chances of Welsh speakers as minority language service users. Implications for our health and care services include, but are not limited to:
- Need to improve the availability of health and care services through the medium of Welsh;
- Ensure that the requirements of the Welsh Language (Wales) Measure 2011 and the 'More than Just Words' Framework are fully met.
## Appendix 2 – Points Raised at Mid-Point Review and Action Taken

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| **1. Production of an updated EQIA and a plan for a regular and dynamic update** | The Equality Impact Assessment (EQIA), undertaken for the consultation, was formally reviewed and updated as part of the work based on:  
- what we heard during the consultation  
- cross referencing the stakeholder mapping with the consultation plan to ensure target audiences were addressed  
  
Amendments to the EQIA were dated and highlighted to ensure the changes made were clearly identifiable. The amendments were also identifiable when accessing the document online through the change to the published date and the version control table at the front of all amended documents identifying what has changed. |
| **2. Monitoring of penetration of Polish and BSL translated material** | Advice was sought from the BAME ((Black, Asian and Minority Ethnic) group about the best ways to improve engagement with the Polish community. It was suggested the most effective approach would be informally through the local Polish food shops. A poster was designed and distributed to raise awareness of the consultation. The BSL version of the animation was made available at public drop in events, shared at specific meetings relevant to this community group as well as being publically available on our website. |
| **3. The Rights of the Child (Article 25)** | A range of activities were scheduled within the consultation in order to engage with young people. Following reflection the programme of engagement with young people was strengthened. Much of this had already been planned but the full programme was expanded to include:  
- Dedicated youth video shared through young people friendly social media and paid for social media advertising targeting age range  
- Documents shared with Project Co-ordinator (Young People) Wales, Aberystwyth University and University of Wales Trinity St David’s  
- Focus Group with Carmarthen Youth Council and Pembrokeshire Youth Assembly  
- Screening of youth friendly video on a continuous loop in Coleg Sir Gar Llanelli reception from 13 June 2018, and on a rolling basis throughout the remainder of consultation period.  
- Stalls and drop in at Coleg Sir Gar Llanelli, Pembrokeshire College, Coleg Ceredigion Aberystwyth, Ysgol Cwmpadarn and Coleg Ceredigion Cardigan |
| **4. Dynamic engagement with protected characteristic groups** | The approach to consultation was to listen and adapt the approach based on what we were hearing, and this was also informed by analysis of Equality Monitoring Forms completed at public drop in events to gauge whether there was sufficient reach with target audiences during the consultation period. Sections 1, 2 and 3 |
above reflect the review process and demonstrate actions taken to further enhance the consultation plan. Specific activities with groups with protected characteristics were outlined and monitored throughout. See further section 5.2, relating to Equalities.

| 5. **Clarification of the consultation materials in response to issues emerging from the consultation to date** | The approach to consultation was to listen and adapt based on what was being heard and whether there was effective engagement and communication with the audience during the consultation period. Feedback indicated there was a need for further clear and concise information and the following was developed in response:
- Short clinical videos to demonstrate consultation is clinically led
- ‘Setting the record straight’ and ‘what we are hearing’ slideshows to address inaccuracies and demonstrate listening
- Emergency access video to clarify role of Emergency Medical Retrieval and Transfer Service and WAST – treatments starts at the scene
- Communication narrative to better explain what can be provided at a Minor Injuries Unit and what needs to go to an emergency and urgent care hospital
- ‘What care from where’ leaflet to localise information |

| 6. **Travel and transport implications** | Transport and travel issues came through clearly during the “Big Conversation” engagement and continued to be key issues raised during the formal consultation process at public and staff events. To ensure a further level of detail around these issues the following actions were taken:
- Working with the regional transport group to put together a new regional transport plan
- Face-to-face residents survey sessions undertaken by ORS to ensure respondents have the opportunity to express their travel and transport concerns as part of the session to complete questionnaires from an informed perspective
- Additional public drop-ins to have a travel board to enable participants to raise their travel and transport concerns
- Briefings at the start of public drop-ins to emphasise the need to further explore with participants any travel or transport concerns raised to help us better understand specific issues.
- Presence of WAST colleagues at all consultation events to enable participants to have detailed conversations about their travel and transport concerns. |

| 7. **Risk of failure to provide quantitative balance to the consultation** | The original plan had been to undertake a targeted Residents’ Survey to act as a balance to the consultation questionnaires completed during the consultation period. The final questionnaire was longer than anticipated and consequently it was not possible to adapt to a format that could be delivered by telephone. |
Discussions with ORS led to an alternative approach of face-to-face residents survey sessions being held to enable opportunities for participants to better understand the proposals before commenting on the consultation. The communities covered include:

Carmarthenshire – Amman Valley, Carmarthen, Cross Hands, Llandovery, Llanelli  
Ceredigion – Aberaeron, Aberystwyth, Cardigan, Tregaron  
Pembrokeshire – Haverfordwest, Pembroke Dock, Tenby

It was estimated around 150-200 people could be targeted in this way. During these face-to-face residents survey sessions participants were presented with information and completed the questionnaire during the session. Following further discussions with ORS it became clear it was far more likely the number of people attending was nearer the 150 than 200. The approach was discussed with the Consultation Institute and it was agreed the number of people completing questions at these events needed to be a minimum of 200. Based on this feedback additional events were requested before the end of the consultation at the following locations:

Carmarthenshire - Whitland  
Ceredigion – Lampeter  
Pembrokeshire – Fishguard, Milford Haven, Crymych

| 8. Further engagement with stakeholders | Protest groups and some of the most active social media campaigners were emailed and invited to meet with senior representatives of Hywel Dda UHB to aid a better understand of their concerns and issues and provide facts to potentially allay some concerns. We committed to continuing the ongoing relationships and dialogue with our politicians throughout the consultation period. |
| 9. Trailing a dialogue around the need for further consultation | A form of words was confirmed for communicating the potential of tweaks to models and the development of hybrid models based on what we have heard when considering the feedback from the consultation. This was used across our media channels including social media. |
| 10. Emerging issues following the mid-point review | Issues emerging as the consultation progressed included:  
- Audio translation of consultation document and consultation questionnaire specifically requested, but arrangements were made to highlight the availability of an audio CD through the Wales Council for the Blind.  
- Invitations to the protest groups, social media campaigners and key politicians to meet with the Chief Executive and Directors leading the Transforming Clinical Services programme. |
### Appendix 3 – Summary of Written Submissions

<table>
<thead>
<tr>
<th>TYPE OF CORRESPONDENT</th>
<th>NUMBER OF RESPONSES</th>
<th>NAME OF ORGANISATION</th>
</tr>
</thead>
</table>
| Health and Care Staff (Individuals and Groups) | 16 | Dyfed Powys Local Medical Team  
Ceredigion County Team Pembrokeshire County Team Bronglais Medical Staff  
Committee Withybush Medical Staff  
Committee Carmarthenshire Consultants  
Committee Healthcare Professionals Forum  
Pathology Operational Leads Group Senior Paediatric Team, Glangwili Hospital  
Brynteg Surgery, Ammanford Swansea University Medical School Individual members of staff x 5 |
| Town and Community Councils and Councillors | 17 | Aberystwyth Town Council  
Bronwydd Community Council  
Carmarthen Town Council  
Ceredigion Town and Community Councillor  
Cilycwm Community Council  
Cwmaman Town Council  
Lampeter Town Council  
Milford Haven Town Council  
Llangunnor Community Councillor  
Llansawel Community Council  
St Clears Town Council  
St Dogmaels Community Council  
Talyllychau Community Council  
Pembroke Town Council  
Councillor Ken Howell (Plaid Cymru response)  
Councillor Alan Lenny (Plaid Cymru response)  
Councillor from the Llangyndeyrn Community (Plaid Cymru response) |
| Members of Parliament, Political Parties, Groups & Representatives | 16 | Children’s Commissioner for Wales  
Older People’s Commissioner for Wales  
Carmarthen East & Dinefwr Conservatives and Ceredigion Conservatives  
Carmarthen East & Dinefwr Labour Party  
Ceredigion Constituency Labour Party  
Welsh Liberal Democrats  
Stephen Crabbe MP  
Paul Davies AM |
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<td>Aberystwyth &amp; District Probus Club &amp; Friends</td>
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<td></td>
<td></td>
<td>Amman Valley Hospital League of Friends</td>
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<td></td>
<td></td>
<td>Breathe Easy Pembrokeshire</td>
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<td>MENCAP Ceredigion</td>
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<td>The Bandi Appeal</td>
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<td>The Stroke Association</td>
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<td>Carmarthenshire County Council</td>
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<td>Ceredigion County Council</td>
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<td>UNISON</td>
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<td>The Save our Services at Prince Philip Action Network (SOSPPAN) Campaign</td>
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<td>Local Residents</td>
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<td><strong>Total</strong></td>
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Appendix 4 – Petitions

Petition relating to Withybush Hospital - 40,045 signatures

The following petition, organised by Myles Bamford-Lewis and signed by 40,045 people, was submitted to Welsh Government on 17th July 2018:

PEMBROKESHIRE SAYS NO!! TO THE CLOSURE OF WITBYBUSH A&E!

We the undersigned are calling on the Welsh Government and Hywel Dda Health Board to reverse their decision to downgrade our county hospital and to remove our A&E.

The Hywel Dda Health Board has proposed drastic changes to how hospital services are provided in West Wales. They propose a downgrading of our county's Withybush general hospital and Carmarthenshire's Glangwili general hospital, both to community hospital standard and a new general hospital to be built around the Whitland area. But this also means that we will no longer have a fully functioning A&E department within our county as it will be replaced by a minor injury unit at the Withybush site. In doing so patients who require emergency care in our county will be faced with traveling for up to an hour, possibly even more if you live in our county's more rural areas just to have that life-saving emergency care in a hospital that will be outside the county. A time scale that not only is putting Pembrokeshire lives at risk but doesn't even factor in that added time of having to wait for an ambulance to get to where a patient may be, stabilising the patient, then transporting that patient to a hospital that is beyond the borders of our county. Crucial minutes lost in a situation where time is already not on your side.

Having no A&E department within our county is completely unacceptable and is all in the name of cutting costs but more importantly cutting corners. Well Pembrokeshire is one corner of Wales that we will not let them cut us off the map!

Please sign and share, we can't let the Welsh Government and the Hywel Dda Health Board take our county's greatest asset away from us. They've already taken our SCBU [Special Care Baby Unit], our Consultant led maternity and our 24 hour paediatric care away from us...already putting our babies, children and mothers at great risk! Now they are coming to finish off the rest of our county's hospital services. Please don't let that happen!

Together we will send Steve Moore and Vaughan Gething a message that they can think again if they think Pembrokeshire will go down without a fight while they strip our hospital away from us!
Petition relating to Amman Valley Hospital - 6,583 signatures

The following online petition, organised by Emyr Rees, was signed by 6,583 people:

PLEASE HELP TO SAVE AMMAN VALLEY HOSPITAL FROM POSSIBLE CLOSURE!

Save Amman Valley Hospital

Since 1936 our hospital has provided much needed health services close to home and specialist outpatient services for people across the whole of Carmarthenshire.

We have faced the most severe pressures in our health services because there are simply not enough beds to provide the care people need. Closing beds therefore makes no sense. Expecting people to travel to see their loved ones is not an option. Relieving pressures on our busy District General Hospital, wherever they are, through community-based provision is good for patients and the entire local health service.

Carmarthen East and Dinefwr Labour party says rather than reduce or cut services at Amman Valley Hospital they should be extended, and we call upon Hywel Dda University Health Board to save Amman Valley Hospital and open a Minor Injuries Unit as a matter of urgency.

Petition relating to Glangwili Hospital - 3,626 signatures

The following online petition, organised by Alun Lenny and supported and promoted by Carmarthen Town Council, was signed by 3,626 people:

KEEP A&E AT GLANGWILI OR BUILD NEW HOSPITAL AT CARMARTHEN

Hywel Dda Health Board’s options for a ‘once in a lifetime’ transformation of hospitals in west Wales propose downgrading three general hospitals and building a new ‘super hospital’ near the Carmarthenshire/Pembrokeshire border.

We call on the Health Board to consider locating the new hospital near Carmarthen town. If not, the A&E department at Glangwili must be kept open.

A new hospital, just west of Carmarthen, would be equidistant from Llanelli and Haverfordwest. It would be well-served by the A40 dual carriageway, the main
road through west Wales. The Swansea-Pembrokeshire railway passes nearby and a new ‘parkway’ station would cut the need for car parking by staff, patients and visitors. It would be within an hour of St David’s in the far west and Llandovery to the east. Carmarthen seems the logical place to locate a new hospital to serve west Wales.

Petition relating to Prince Philip Hospital - 421 signatures

The following online petition, organised by Kelly Darby, was signed by 421 people:

SAVE OUR FACILITIES AT PPH

Bring all facilities back to PPH and give us our own maternity and children’s ward and funding for more ambulances.

Why is this important?

We have an up to date hospital in Llanelli and a bigger population than Carmarthen. Downgrading is putting lives at risk and lack of out of hours is not just a risk for future generations and the elderly but also those that don’t have transport to travel or those that are agrophobic. Waiting times for ambulances that carry defibrillators are ridiculous too.

Petition expressing support for HDdUHB’s proposals for Bronglais Hospital and a new hospital in the south of its area - 209 signatures

209 people supported the following consultation response from the Aberystwyth & District Probus Club & Friends, which: expresses support for retaining Bronglais as a District General Hospital and for consultation Proposal A (which will, it is felt, best address the health board’s current challenges); and urges HDdUHB to retain both elective and emergency surgery at Bronglais, maintain bed numbers across its area, properly finance and staff its proposed community model, improve its digital communications and lobby WG for improved infrastructure, especially north of the M4 corridor:

It is clear to our members that the latest HDUHB "Our big NHS change" document, a simplified version of its new proposals for structural change in the delivery of health care in the region, has been heavily influenced by the highly critical detailed Ceredigion Local CAC response and input from the ABER group to its original proposals. Contrary to the downgrading of Bronglais (BDH) it is encouraging to see it retained as a General District Hospital in all of the 3 proposals for health care in the region. This has also taken on board many of the points covered by
Marcus Longley's report some years ago. The subsequent work by the Mid Wales Collaborative has built on these.

We appreciate the huge strides the current leadership of the HDUHB has made to develop trust with the people of Mid Wales and the proposed strategy for BGH to play an important role within the hospital setting and also to extend its support for outreach services into Ceredigion, south Gwynedd and Powys. But the continued support of the population cannot be taken for granted and HDUHB must ensure that its integrity remains fully intact through open and honest dialogue with the people it serves. At this particular moment in time we are keen to learn about the proposed new MRI scanner and the fate of the one currently in use at Bronglais!

We are greatly encouraged to see that Bronglais will be retained as a District General Hospital in all 3 proposals for health care in the region. We feel strongly that Bronglais should provide elective and emergency surgery even if HDUHB elects to split these services in the south. We accept that this may lead to cancellations but we feel it is an acceptable trade off to have a viable DGH. We will be very concerned if the re-organisation leads to a loss of capacity in bed numbers. As it is, the region's health services cannot manage winter pressures on bed numbers as they are.

Such changes, especially as proposed in option A, should have an immensely positive impact with respect to the retention and recruitment of able health practitioners that will be so important for the delivery of quality health care in Ceredigion, South Gwynedd and West Powys. To a greater extent than any of the other regions in Wales a higher proportion of residents are more remote from health care services and have to cope with travelling greater distances on lower grade roads.

We understand the challenges identified and the plans the Board has outlined to improve health provision. Of the three suggested proposals we favour A as this would concentrate resource into an urgent care and planned new hospital near Narberth & St Clears and a general hospital in Aberystwyth. That will provide for A&E services in Pembrokeshire, Ceredigion and a large part of Carmarthenshire.

Underpinning the centralisation of such services is the development of the Community hospitals and hubs. Together with improved Care in the Community, these must be properly financed and staffed to ensure that the proposed new hospital and its location will fulfil the needs of all the people served by HDUHB. We are aware that such services will require heavy resources up front but may provide real savings in the future. There is a reliance on community resilience but what extra support will be available to make carers and local communities more self-reliant?
Diagnostics are key to good outcomes in remote areas and quick access to them is essential. All these developments rely on good digital connectivity and this is an area much in need of great improvement in the NHS and with provision of high speed internet facilities in the more rural areas. Additionally, paper communications, which can take a week to move from one hospital to another, or to a GP surgery, should largely be a thing of the past and be supplanted by a secure electronic system. This should include a secure email system to facilitate communication between doctor and patient when it is considered appropriate (as operates in parts of the English NHS). This latter point may be of particular importance to patients in rural areas being treated in a larger centre in another part of Wales.

While we recognise that this will involve some people having to travel further to a main hospital, proportionally this burden is more evenly spread so that residents in Ceredigion and Pembrokeshire will shoulder less of this inconvenience than is currently the case. Residents in South and East Carmarthenshire may feel aggrieved by the downgrading of Prince Philip Hospital, which has served them well but they are well placed being close to the M4 to avail themselves of the much-vaunted specialist services available in Swansea, Bridgend and Cardiff. Travel times to reach such facilities are a fraction of those faced by residents in Ceredigion, South Gwynedd and West Powys in addition to which public transport is much more accessible.

With respect to proposal B, while we can see the advantage of having three main hospitals it will dilute the resources to the other health services, have problems with maintenance and staffing levels making it less attractive to new staff and would likely lead to more cancellation of routine operations. This in our opinion will undermine the efforts of the Board to make significant improvements in the region. Implementation of proposal C will, we believe, will lead to the concerns you have identified.

Finally, having recognised that our road infrastructure north of the M4 corridor have major implications with respect to cost and the provision of health care we believe that the Board should reiterate its concern to the Wales National Assembly to ensure that greater efforts are made to bring our major roads up to the highest standards in Europe.
Appendix 5 – Glossary of Terms

24/7: 7 day services, 24 hours a day.

A&E: Accident & Emergency department.

ABMUHB: Abertawe Bro Morgannwg University Health Board.

Acute hospital care: Short-term treatment, usually in a hospital, for patients with any kind of illness or injury.

Ambulatory Care: Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.

ARCH: A Regional Collaborative for Health between Swansea University, Abertawe Bro Morgannwg University Health Board and Hywel Dda University Health Board.

Care Co-ordinator: A role to supervise interdisciplinary care by bringing together the different specialists whose help the patient may need, the coordinator is also responsible for monitoring and evaluating the care delivered.

Clinical Pathways: structured, multidisciplinary plans of care designed to support the implementation of clinical guidelines and protocols. They provide detailed guidance for each stage in the management of a patient (treatments, interventions etc.) with a specific condition over a given time period, and include progress and outcomes details. Clinical Pathways aim to improve, in particular, the continuity and co-ordination of care across different disciplines and sectors.

Cluster: A Cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally. Clusters are determined by individual NHS Wales Local Health Boards (LHB’s). GPs in the Clusters play a key role in supporting the ongoing work of a Locality Network. In Hywel Dda, there are seven clusters, covering populations of approximately 50,000 residents.

CHANTS: Cymru inter-Hospital Acute Neonatal Transfer Service

CHC: Community Health Council.

Co-Design/Co-Production: Co-production is an approach to public services based on equal and reciprocal relationships between professionals, people using services, their families and their communities. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.
**Commissioning:** The process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.

**Community Health Services:** Community health services cover ‘cradle-to-grave’ services that many of us take for granted. They provide a wide range of care, from supporting patients to manage long-term conditions, to treating those who are seriously ill with complex conditions. Most community healthcare takes place in people’s homes. Teams of nurses and therapists coordinate care, working with professions including GPs and social care. Additionally community health provides preventative and health improvement services, often with partners from local government and the third sector. Although less visible than hospitals, they deliver an extensive and varied range of services.

**Continuous Engagement:** involves ongoing research and consultation rather than just engaging at critical moments, engagement across multiple touchpoints and ensuring that residents are at the heart of an organisation’s culture and involving them at the earliest possible stage of idea development.

**Diagnostics:** Investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms.

**Digital Technology:** the use of PC’s, tablets and mobile devices such as smartphones to support a number of everyday online activities, and specifically how technology and greater access to information can be used to help improve people’s health and well-being.

**Early Intervention:** is about taking action as soon as possible to tackle problems for people before they become more difficult to reverse.

**Emergency care:** Hospital-based service available 24 hours, seven days a week for urgent medical care and medical and surgical emergencies that are likely to need admission to hospital.

**EMRTS:** Emergency Medical Retrieval and Transfer Service. EMRTS Cymru is also referred to as the Welsh Flying Medics.

**Equality Act (2010):** The Equality Act became law in October, 2010. It replaced previous legislation (such as the Race Relations Act 1976 and the Disability Discrimination Act 1995) and ensures consistency in what employers and employees need to do to make their workplaces a fair environment and comply with the law.
Feasibility study and options appraisal: A feasibility study is a study that assesses the viability of an idea. It seeks to identify potential problems and to determine whether an idea will work. It provides details on how a business can succeed, and it serves as a tool for creating a good business plan.

General Hospital: A non-specialised hospital, treating patients suffering from all types of medical conditions. (Also see Community Hospital.)

GP locality: A smaller group of GP practices within the Hywel Dda area. There are 8 localities in Hywel Dda.

GP: General Practitioner. A doctor who is on the GP Register (a register of doctors who are able to work in general practice in the health service in the UK) of the General Medical Council and who has a current Licence to Practise.

Hywel Dda UHB: Hywel Dda University Health Board.

IMTP: Integrated Medium Term Plan: Planning document based on a three year planning cycle that is required by the Welsh Government by each Health Board within Wales.

Integrated care: Care which is co-ordinated around the patient, making sure all parts of the NHS and social care work more closely and effectively together.

IT: Information Technology

MIU: Minor Injuries Unit, for assessment of injuries that are not serious.

Network of Care: organisations working more closely together in the community, including primary, community and social care, and the voluntary sector, to offer more care and support closer to home. This can involve the provision of services in a building, such as a community hub or hospital, within a patients home, or even virtually.

NHS: National Health Service. First started in 1948, it was designed to provide free health care to all in the United Kingdom. It has expanded rapidly, funding research and providing care for people in all medical fields.

Organisational Development: In the NHS, the purpose of Organisational Development is to improve the quality and safety of patient care and enabling people to transform systems. Organisational Development is a field of practice where behavioural science is applied to organisational and system issues in order to align strategy and capability. It enhances the effectiveness of systems through the
provision of interventions that build capacity and capability to achieve collective goals.

**Out of Hours (OOH):** The period of time outside of normal working hours, usually meant to be before 9am and after 5pm and on weekends.

**Outpatient:** A patient who attends an appointment to receive treatment without needing to be admitted to hospital (unlike an inpatient).

**Patient flow:** refers to the process patients follow from the moment they are admitted to hospital to when they are discharged, this may be through accident and emergency, appointments with specialists and other channels, and involves diagnosis and treatment decisions.

**Phase 1:** The first phase of our Transforming Clinical Services Programme. This involved listening to the views of local people and patients who have used our healthcare services, through our engagement exercise ‘The Big Conversation’; and examining our current services in detail with our doctors, nurses and healthcare professionals.

**Phase 1 Output Report:** The report we wrote at the end of Phase 1, to summarise what we found out.

**Planned care:** (also known as elective care or elective surgery) – a planned operation or medical care.

**Population health:** The health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire human population.

**Prevention:** measures and actions taken to avoid disease and ill-health, which can include lifestyle choices and environmental factors.

**Primary Care:** Primary care is the day-to-day healthcare given by a health care provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a healthcare system, and coordinates other specialist care that the patient may need. Patients can access primary care services through their local general practice, community pharmacy, optometrist, dental surgery and community hearing care providers.

**Protected Characteristics:** the nine groups protected under the Equality Act 2010. They are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex; and sexual orientation.
**Prudent Healthcare**: The four principles that guide the NHS in Wales. These are: Public and professionals are equal partners through co-production; care for those with the greatest health needs first; do only what is needed and do no harm; and reduce inappropriate variation through evidence-based approaches.

**PSBs**: Public Service Boards.

**Risk stratification**: A tool for identifying and predicting which patients are at high risk or likely to be at high risk.

**Seamless care**: Coordinating health and social care services so that they wrap around the needs and preferences of the individual, so that it makes no difference who is providing individual services.

**Secondary Care**: Secondary care includes acute care: necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services. The term "secondary care" is sometimes used synonymously with "hospital care". However, many secondary care providers do not necessarily work in hospitals, such as psychiatrists, clinical psychologists, occupational therapists, most dental specialties or physiotherapists (physiotherapists are also primary care providers, and a referral is not required to see a physiotherapist), and some primary care services are delivered within hospitals.

**Social media**: Computer-mediated technologies that facilitate the creation and sharing of information, ideas, career interests and other forms of expression via virtual communities and networks.

**Social Model for Health and well-being**: The social model of health and well-being considers a broader range of factors that influence health and wellbeing, for example, environmental, economic, social and cultural.

**Social prescribing**: Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Recognising that people’s health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people’s needs in a holistic way. It also aims to support individuals to take greater control of their own health. Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.
Social Services and Wellbeing (Wales) Act (2014): The Social Services and Wellbeing (Wales) Act is the law for improving the well-being of people who need care and support, and carers who need support.

Step-down beds: An alternative to early supported discharge when the patient cannot be supported at home but no longer needs to be in an acute hospital.

Step-up beds: An alternative to hospital admission when the patient cannot be supported at home but does not need to be in an acute hospital.

Transforming Clinical Services programme (TCS): Transformation programme to deliver a healthcare system of the highest quality, with excellent outcomes for patients.

Telemedicine/Tele-health: Use of telecommunication and information technology to provide clinical health care from a distance.

Third Sector: ‘Third sector organisations’ is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

Unscheduled care services: Accident and emergency care services.

Virtual Clinics: A planned contact by the HealthCare Professional Responsible for Care with a patient for the purposes of clinical consultation, advice and treatment planning.

Wales Ambulance Service Trust (WAST): Provides high quality pre-hospital emergency care and treatment throughout Wales.

WATCH service: Wales and West Acute Transport for Children

Wellbeing: means a person is happy, healthy and is comfortable with their life and what they do. Under the Social Services and Wellbeing (Wales) Act 2014, wellbeing relates to any of the following - physical and mental health and emotional well-being; protection from abuse and neglect; education, training and recreation; domestic, family and personal relationships; contribution made to society; securing rights and entitlements; social and economic well-being; suitability of living accommodation.
**Wellbeing of Future Generations Act 2015**: The Well-being of Future Generations (Wales) Act 2015 is about improving the economic, social, environmental and cultural well-being of Wales through sustainable development.

**West Wales Area Plan**: The West Wales Regional Partnership Board’s plan for how partners will work together over the next five years to continue the transformation and integration of care and support in West Wales, in line with the aims and values that underpin the Social Services and Wellbeing (Wales) Act.

**West Wales Regional Partnership Board**: A Board established to drive the strategic regional delivery of social services in close collaboration with health.

**Whole system**: An approach that recognises the contribution that all partners, including patients, make to the delivery of high quality care.

**Workforce**: the staff that are employed to work for Hywel Dda UHB to provide specific services, activities or projects.